THE POTENTIAL OF GLOBAL PAYMENT: INSIGHTS FROM THE FIELD

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ABSTRACT: Increasing awareness of cost and quality problems caused by the prevailing fee-for-service payment system has led to a reemergence of interest in payment models that build on the capitation approach, generally referred to as global payment. This project interviewed and surveyed physician leaders of small and large organizations, as well as other industry experts with experience with managed care in a variety of global payment arrangements, to glean insights into global payment successes and failures. Results showed that many issues plaguing capitation payment programs in the 80s and 90s have largely been resolved and that physicians and industry leaders felt that cost reductions of 20 percent to 30 percent are achievable under well-constructed global payment models, while improving quality of care. Industry experts strongly recommended that a range of global payment structures be phased in and applied to both large and small physician entities.

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CONTENTS

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EXECUTIVE SUMMARY

In the 80s and early 90s, health care providers in the managed care world were frequently paid via capitation—that is, a flat fee per patient. Use of the practice has eroded significantly, but experienced provider and plan leaders believe moving to improved models of capitation, called global payment, would result in much better care for all types of patients at more reasonable cost. In researching this report, the author interviewed 16 individuals from four geographic markets with extensive expertise managing capitation and global payment. These experts unanimously supported global payment and estimated that proper alignment of payment and quality incentives could generate a 20 percent to 30 percent cost reduction while greatly improving care quality. They believe it is now possible to resolve problems that plagued capitation in the past, such as avoidance of sicker patients and excessive risk assumption, but that environmental changes have also created new challenges.

THE NEW ENVIRONMENT

Global payment can address concerns about both quality and cost. The need to mitigate cost increases is largely behind the resurgence of interest in global payment approaches, but many quality issues inherent to fee-for-service can also be addressed by using this model.

Risk adjustment has successfully resolved past problems with provider avoidance of sicker members. Implementation of risk-stratified global payment means that insurance risk has been separated from patient-management risk for providers. Attracting healthier patients and avoiding sick patients was the key to success in the old capitation payment models, but this incentive is corrected with risk adjustment. Reinsurance is also now commonly available through health plans and reinsurers. In some cases, provider reserves are adequate to carry the risk. The degree of risk can be tailored to the capacity of provider organizations.

Clinical and financial data systems have improved. Today, providers with fully implemented electronic medical records are well positioned to optimize patient care and some have real time, clinically complete information. Better information systems coupled with global payments are supporting innovative approaches to patient care such as patient registries, outreach and patient education, Web visits, home monitoring of clinical status, and long-distance virtual visits.

Hospitals have consolidated and many have acquired primary and specialty physician capacity. Hospital integration with physicians creates an opportunity for incentive alignment across the delivery system. Hospital access to capital can support investments in systems and staff

needed to improve patient care cost and quality. But, accountability for a population-based budget is new to hospitals that are more accustomed to trying to keep their beds full. By using global payment, hospitals can improve quality and cut costs by reducing the frequency and intensity of inpatient care—the opposite of current hospital financial incentives.

Plan designs and self-funding do not always mesh with global payment products. Combining deductibles and coinsurance with global payment models requires claim adjudication and collection of the patient's share of cost. Administration of global payments for self-funded employers also presents a challenge.

Patients have greater expectations of unlimited provider choice. Patients have grown accustomed to unfettered provider choice and loosened rules for service authorization but they may opt into tighter global payment networks if offered incentives.

Our "more is better" culture has not changed. Important drivers, such as fear of rationing, defensive medicine, and the imperative to "do something," dominate our culture and affect both patient- and provider-generated demand.

Expert Insights on What Works and What Does Not

Patient care suffers in the fee-for-service environment. Under a fee-for-service model, patients can experience gaps in care or excess care, resulting in increased probability of complications. Global payments have the flexibility to provide better care to patients, particularly to the chronically ill who benefit from care management services. Providers feel care is much better for patients under global payment and report improved levels of professional satisfaction when working outside the limitations of fee-for-service medicine.

Global payment is necessary but not sufficient to reverse unsustainable cost trends. Global payment is needed to enable investments to optimize care for the chronically ill, which is driving the vast majority of the nation's health care costs, but payment change alone is not enough. Provider leadership, techniques for management of patient populations, data support, alignment of individual provider reimbursement, excess capacity of hospitals, and specialist- and patient-driven demand all must be addressed.

Pay for outcomes. Paying for patient care quality outcomes, along with financial accountability for total cost of care, would reset the emphasis of the delivery system. Comparative clinical effectiveness information is a long-awaited tool to support better patient and physician decision-making on care interventions.

A full range of provider structures can operate successfully under global payment. Very large, hospital-dominated systems, large multispecialty clinics with and without hospital ownership, mid-sized primary care practices, and independent practice associations (IPAs) representing very small primary care practices all have found ways to succeed in global payment programs.

Global payment should be tailored to provider risk capacity and should be phased in over time. There should be a pathway toward full global payment and intermediate models should be supported indefinitely with incentives to move along the global payment continuum. Fee-for-service alternatives should be made less attractive. Excess capacity created through improvements in quality and resource use will take time to be repurposed and financial support to ease this transition should be considered. Global payments must include both cost and outcome accountability and be risk-adjusted to account for differences in the health status of patient populations.

Increasing consolidation should be anticipated. Provider consolidation will likely occur with broader use of global payment, with both positive and negative consequences. Consolidation to promote integration was considered highly desirable. Antitrust and Stark anti-kickback laws make virtual integration challenging and should be amended to better enable innovation within these structures. Experts were concerned about the relative absence of the Federal Trade Commission in preventing anticompetitive consolidation.

Global payment should apply to a critical mass of patients including Medicare. Without global payment for a critical mass of patients, providers cannot make the necessary changes and investments to improve and streamline patient care. A combination of aligned but not identical payment structures can be used, as long as the incentives are directionally consistent. Medicare, by far, has the biggest impact, with reimbursement incentives that drive the business models of physicians and hospitals. Current Medicare fee-for-service payments lock providers into a set of activities based on margins, not patient needs.

Episode-specific bundled payments can be a part of payment reforms but should not stand on their own. Bundled payments are a positive step within an overarching global payment model. They could be especially useful in raising awareness across providers about how to better work together to improve cost and quality. However, bundled payments are seen as overly hospital-centric and are considered easy to manipulate, hard to implement, difficult for smaller physician practices, and not robust enough to drive widespread change.

The amount of payment, as well as the form of payment, is critically important. If the increase in the actual amount of global payment is not controlled, reengineering of health service

delivery will not occur and savings will not be achieved. It is unclear that the market alone can discipline the rates of global payments or equalize variation in costs across the country. In most cases, there is no benefit for providers who agree to lower global payment amounts. Consumer incentives to use lower cost providers or an excise tax on higher-than-market global payment amounts could help control global payment amounts.

Downstream provider payments must align. Current methods of compensation to individual providers based on volume are counterproductive under global payment. Better strategies include combinations of payment based on salary, panel size, patient retention, performance on quality and patient satisfaction measures, and bonuses or penalties based on organization-wide performance. Physicians in independent practices can be paid based on the services they provide, coupled with a bonus or higher fee levels based on individual and organizational performance.

Leadership and personal relationships are the foundation for success in global payment. Successful implementation of new forms of payment relies heavily on provider and plan leadership. Local relationships are critical, as the delivery system changes and reductions in redundant resources required for success must be made on a local level. Innovative, highly effective approaches to improved management of patients require extensive, hands-on involvement of primary care physicians and their colleagues.

Global payment models require major hospital transformation. Current hospital incentives encourage increased admissions for high-margin conditions, but much of the cost savings under global payment comes from avoidance of admissions. Under global payment, services that were profit centers instantly become cost centers. Physicians expressed concerns about hospital-centric bundled payments and accountable care organizations. Hospitals failed in past capitation arrangements when they assumed financial risk but could not manage the physicians who were their biggest admitters. Up to 30 percent reductions in needed hospital capacity were predicted under widespread adoption of global payment. This will create a transition problem that must be addressed.

The role of health plans will evolve. Some providers are considering bypassing plans to contract directly with employers or become licensed as insurers, but plans believed that provider organizations under global payment models need plan oversight. Neither plans nor providers were happy with current approaches to establishing global payment rates and risk-sharing arrangements. Plans can add value by tailoring risk to provider capabilities, developing networks and products that align patient incentives, supporting employee and employer wellness activities, and helping patients learn more about the value and cost of health care interventions.

Economic alignment with patients would improve opportunities for patient advocacy and help overcome patient suspicion. Changing long-held consumer beliefs about the value of health care services is essential to improving the cost and quality of care. Aligning benefit and cost-sharing incentives for patients was identified as the best way to achieve this change.

SUMMARY AND CONCLUSIONS

Global payment, coupled with incentives to improve care outcomes, has the potential to improve health care value. While not all providers may be successful in this environment, size alone should not be a barrier. Better management of patient care is expected to generate a surplus of hospitals and specialists that will need to be redeployed.

The Center for Medicare and Medicaid Services (CMS) must lead payment reform. The private market cannot drive change by itself, but will generally follow CMS's lead. A range of approaches to global payment should be designed and supported. While a phased-in transition period is recommended, with a critical mass of aligned incentives, many feel change will occur rapidly. Improvements in working conditions and rewards for primary care are necessary to ensure the capacity for management of patient care and resource use. Global payment will enable efficiencies from new models of care, fully implemented electronic medical records, and better use of physician extenders to enhance primary care capacity. Global payment models were expected to drive provider consolidation, with attendant pros and cons. It is important to ensure that the positive aspects that consolidation and integration can bring are encouraged, while excess market power and solidification of excessively high costs are avoided. The public consciousness of what constitutes value in health care needs to be raised. Alignment of patient incentives to engage them in value decisions about their care and commit them to actions to support their own health is essential to supporting the efforts of providers to improve cost and quality.

Absent the improved incentives for cost and quality performance of a health care market dominated by global payment, other health reforms that bring more lives into our existing system will exacerbate existing cost problems. With several decades of experience, now is the time to build on what we know and expand these payment models across the system.

THE POTENTIAL OF GLOBAL PAYMENT: INSIGHTS FROM THE FIELD

INTRODUCTION

With growing interest in realigning payment incentives for the health care delivery system, there is much that can be learned from current and past experiences in global budgets. In the 80s and early 90s, use of capitation payment—that is, a flat fee per patient—to providers was common in the managed care world, particularly so in the handful of U.S. markets dominated by large physician-led group practices or independent physician associations (IPAs).

By the late 90s, use of this payment approach had eroded substantially, totally disappearing in some markets and often leading to dismantling of the infrastructure that had been developed to support it. Some markets still have ongoing capitation arrangements with certain providers (primarily under Medicare Advantage plans), but the approach to capitation has changed.

Experts Believe That Global Payment Benefits Patients

Patients get better care: Global payment enables financial support for care management services of all kinds. Fee-for-service medicine does not pay for services that are required for care coordination.

Costs are better managed: Global payment encourages the right care at the right time for patients. Fee-for-service drives up costs by encouraging service volume without consideration of value.

Innovation in care delivery is possible: Global payment enables an emphasis on what works, not just what pays.

Experienced provider organizations and plans report that global payment works very well in both large and small provider organizations, resulting in improvements in both resource use and patient outcomes. A number of provider organizations are thriving today under global payment arrangements and many of those who worked in this type of model long to work in it again. They believe patient care is enormously improved when providers are freed from the perverse incentives of fee-for-service medicine and allowed the opportunities for innovation afforded under global payment.

This paper examines a range of topics related to "global payment"—defined here as forms of reimbursement by plans or other public or private purchasers to health care providers that are substantively tied to provider performance in the management of the total cost of care for a population of patients. Today, insurers, health plans, public purchasers, and self-funded employers operate under a global budget. The budget may be dictated by premiums collected, legislation, or by an amount the employer has set aside for claims against a self-funded plan. However, this overall global payment budget is not duplicated in the health care delivery system.

Within the payer's budget, services delivered to beneficiaries are most commonly purchased on a fee-for-service basis. Global payment reflects a change from payment based on each service rendered to payment for all or part of the total array of services required to provide care to the patient population served by the provider.

For purposes of this paper, global payment takes a variety of forms—commonly incorporating strong financial incentives for providers to use health care resources judiciously but without the fee-for-service coverage limitations that pay for only certain types of services (e.g., physician office visits, but not phone calls or Web visits) or the distortions imposed by the profitability of one type of service over another (e.g., procedures are profitable, but cognitive services are not).

This report examines variations in existing global payment arrangements, as well as optimal construction of global payment structures, as suggested by experts. In the following discussion, it should be noted that global payment models share some characteristics with traditional capitated payment models, but corrections for flawed incentives to avoid sick patients, combined with vastly improved understanding and technologies for managing costs and patient care, have created new ways of thinking and operating.

THE PROJECT

The intent of this project was to collect insights and opinions from providers, payers, and other experts who have extensive experience with past or current methods of global payment. Important lessons from provider and payer experiences with capitation and global budgets should inform the next generation of payment models. Indeed, there has been an evolution of thinking and operating based on what has and has not proven effective over time.

Using a structured discussion approach, this project sought to gain qualitative insights into global payment successes, challenges, and new ideas. The researchers conducted 16 interviews (Appendices A and B) and short-response surveys (Appendices C and D) with industry experts who currently or formerly managed global payment arrangements. The objective of this information gathering was to seek advice from the experts. No attempt was made to generate responses that could be statistically analyzed.

Interview subjects had extensive experience managing capitation programs as chief executives and senior executives of a variety of organizations, including IPAs, bringing together many small physician practices, mid-size single specialty primary care practices, large and very large multispecialty and integrated delivery systems, and current and former senior regional and

national health plan executives. In addition, several consultants with longstanding experience working for both plans and providers nationally and internationally were interviewed (Appendix E). Interview subjects were sought primarily in California, Colorado, Massachusetts, and Minnesota, where there has been lengthy and deep experience in these programs.

The following comments represent an amalgam of the perspectives gained through these interviews and surveys. Conclusions and recommendations in this paper are based on the experiences, opinions, and examples given by the providers, payers, and other experts interviewed. Facts or examples cited by these subjects were not quantified or subject to further scrutiny.

WHAT IS GLOBAL PAYMENT?

Global payment comes in many shapes and sizes, but has the common characteristic of holding providers financially accountable, to a greater or lesser degree, for the total cost of care provided to the patient population assigned to them. One critical element, according to the experts, is that financial incentives to manage patient resource use must exceed economic incentives to provide too much or too little care.

Global payment is the next generation of the capitation payment approaches broadly used by HMOs in the 80s and 90s, with programmatic improvements that address the many problems of the more primitive applications. Global payment arrangements are difficult to describe concisely because of the numerous variations that allow for design flexibility to balance payer and provider risks. Organizations currently operating under global payment arrangements have successfully addressed the problems of past capitation models in a variety of ways, but continue to face problems operating with one foot in the prevailing fee-for-service market.

Capitation Problems Addressed in Next Generation Global Payment Models

- Incentive to skimp on care
- Incentive to skim risk
- No accountability for quality
- Limited ability to manage risk
- Limited data
- Patient and provider dissatisfaction with "gatekeeping"
- Lack of provider financial reserves
- Provider reluctance to assume risk

Global payment models vary based on the amount of risk assumed by the provider organization and the methods used to limit risks. Risks can be limited based on what services are included in the global payment and what, if any, adjustments are considered when evaluating provider performance. For example, a provider organization may assume risk for professional services only, while a plan holds the risk of inpatient use and pharmacy. The potential cost exposure for professional

services is minimal relative to the highly variable cost generated by the small percentage of patients who are hospitalized. Alternatively, provider organizations can be at risk for all covered services, but the risk amount may be limited to the approximate amount the provider would have received for those patients if they were paid on a fee-for-service basis.

Risk can also be contained by introducing reinsurance that limits the provider organization's exposure for the cost of care for any individual patient, so that the reinsurer pays for patient care costs in excess of an agreed-upon threshold. The amount of this threshold can be raised or lowered based on the ability of the provider organization to retain risk. Variations also exist in funding and administrative approaches. Reinsurance can be provided by health plans as part of their global payment contract with the provider organization or by external reinsurance purchased on the open market. Some provider organizations have established sufficient reserve funds to self-insure against this type of risk.

The risk to providers of enrolling large numbers of very ill patients that need to be cared for within a global payment budget can be mitigated through the use of risk adjustment. Patients who are ill are expected to require more-costly services. Using technologies that evaluate the illness burden of patients by analyzing their various conditions and comorbidities, the added amount that sicker patients would be expected to need for their care can be calculated and used to adjust the amount of money available for their care. For example, the global payment amount would be greater for a provider organization that cares for more patients with diabetes with multiple comorbid conditions than it would be for a provider organization caring for diabetics with no comorbidities and even greater than the global payment for a group that includes mostly patients of similar age and sex, but without any chronic illness.

Global payments are funded and administered in a wide variety of ways. Particularly with very large integrated provider organizations, an agreed-upon amount of money per member representing the total budget available to care for all needed services for patients under the provider's care is prospectively deposited by the payer in a provider-owned account. Any costs incurred outside the contracted provider organization are then drawn from this account either by the payer or the provider organization.

Alternatively, when the provider is at risk only for a subset of covered services for their patient population, a slice of the expected total cost per member is prospectively allocated into a provider-owned account or into a dedicated account held by the payer. Claims for services that are performed by providers that are not part of the provider organization are typically drawn

from this account and the balance is available to the provider to compensate for the services they have rendered within their system.

In yet other cases, all of the funds based on the agreed-upon global payment budget amount are retained by the payer. Claims are submitted and paid to all providers on a fee-for-service basis during the course of the year, and after year end and a time lag for collection of all claims and analysis, the balance in the account is calculated. Excess funds or overages are retrospectively shared based on the agreement in place between the payer and provider.

Each payer–provider global payment arrangement considers multiple methodological variations. Typically, no two arrangements are the same for providers contracting with multiple plans and for payers contracting with multiple providers. Plans and providers report variations in global payment arrangements including:

- which patients are included (e.g., Medicare, Medicaid, commercial)
- which products are included (e.g., fully insured, self-insured, HMO, PPO)
- how to determine which patients are under the provider's care (e.g., patients specify and lock in provider, patients are attributed to providers based on de facto provider use)
- which covered services are included (e.g., all covered services, all services except pharmacy, all services except mental health, professional services only, primary care services only, etc.)
- methodology and technology used for risk adjustment
- methodology used for adjustment for catastrophic claims
- how risk is limited based on performance levels around a target, (e.g., in some types of arrangements providers can be at risk for +/– 10% of what their fee-for-service payments would have been, with the payer retaining the balance of the risk)
- how providers outside the globally paid organization are contracted and paid
- level of fee-for-service payments or withholds made prior to reconciliation
- timing and data sharing for reconciliation payments.

WHAT HAS CHANGED?

The health care culture and environment has changed significantly since the 80s and 90s, when global payments of varying types were more prevalent. Most of these changes have enabled substantive improvements in the successful management of patient cost and quality, but some changes introduce new challenges.

Today there is a much broader awareness of the compelling problems with the current fee-for-service model. Providers experienced with the economic incentives in non-fee-for-service payment models most often estimated the potential for a 20 percent to 30 percent cost reduction combined with demonstrable improvements in care quality by moving to global payment approaches. Even providers now thriving under fee-for-service recognized that current trends in health care costs are unsustainable. This awareness opens the door to new alternatives that may have been less acceptable in the past. Of course, not all providers are unhappy with the current fee-for-service model. Several experts suggested making fee-for-service programs less attractive by holding or reducing fee-for-service levels while creating upside opportunities using global payment models.

There is a new emphasis on quality. Past use of capitation programs that focused solely on cost management raised concerns by patients, providers, and policymakers about quality and access to care. The ability to measure, compare, and report quality performance has now evolved significantly, enabling provider accountability for quality as well as cost. The economics of global payment models can motivate the use of techniques that can lead to high performance on quality metrics, especially related to chronic illness management. Global payment models can be designed to include added financial incentives for quality performance. Fee-for-service payments were frustrating to the interviewed providers as they are eager to improve care quality. The failure of fee-for-service plans to pay for nonphysician visit-based care management actually obstructs provider investments in the infrastructure and staff needed to improve care, leading to poorer performance on quality metrics for management of chronic illness.

Clinical and financial data systems have improved. In addition to gains in quality awareness and measurement, clinical and nonclinical data systems have evolved. Past capitation efforts were plagued by inaccurate, incomplete, and stale claim-derived financial data. Today, providers with fully implemented electronic medical records are well positioned to optimize patient care and have real-time, clinically complete information available. Under fee-for-service programs, when providers make the investment in electronic medical records, cost savings from care improvements are revenue losses for the provider. In global payment models, these clinical information technology improvements benefit the provider, as well as the patient and the payer. For providers to effectively manage patient care costs they must have accurate and current financial data.

There is still room for improvement, but providers operating in global payment models today have more complete and timely data with which they can manage patient care than they had in the past. Nonetheless, the many variations in global payment methodological details,

combined with continued reliance on using claims data for management purposes, sustain the need for complicated, expensive billing and claims systems to support global payments. Some experts identified opportunities to streamline the claims payment underpinnings of global payments that would reduce the high transaction costs contributing to administrative overhead.

Improvements in information technology have not only improved access to information, they also support profound changes in the way patient care is delivered. Web visits, home monitoring of clinical status, and long distance virtual visits are cost-saving, convenience-enhancing changes in patient care. These innovations are just beginning to thrive in global payment environments, but cannot gain traction in the fee-for-service world since they generally are not reimbursable.

Insurance risk has been separated from patient management risk. Healthier patients predictably require less care than sicker patients. Yet in early capitation models, a patient or population's expected resource needs were not reflected in the amount of the capitation payment. If a patient population was relatively healthy, it was easy to manage within the capitation budget, but if sicker patients enrolled, capitation budgets could quickly prove to be inadequate. Early models sometimes attempted to adjust for patient population characteristics by tying capitation amounts to patient's ages and genders, but this adjustment was inadequate to account for the resource needed when patients had or developed serious illnesses.

With this dynamic in place, plans transferred much or all of their risk to providers, many of whom were not in a position to assume such risk. Thus, it was critical to providers who were accepting capitation to not attract too many patients with serious health needs. Yet, it is patients with serious health needs who can benefit the most—in terms of both outcomes and costs—from the intensive, attentive care management that is the hallmark of good patient management under global payment. Ironically, provider organizations that developed a reputation for great care of complex patients risked bankruptcy if too many of these patients sought care under capitation arrangements.

The amount of risk taken on by providers is now structured to be more consistent with their ability to assume risk. Individual physicians are no longer taking capitation risk and experts contend they should not be permitted to do so. Frequently, provider organizations are now taking on a subset of risks, sometimes limited to professional services. Some more-established, larger provider organizations take global capitation for the entire continuum of care. Others have hybrid arrangements in which professional services are capitated, but there is risk-sharing on hospital costs. Some states now closely regulate the amount of risk providers can assume and plan experts

have suggested there must be checks and balances on global payment. Several providers indicated they can and would prefer to assume more risk, but plans will not agree because they make a profit by retaining inpatient risk.

The introduction of diagnosis-based, risk-adjustment tools has had a large impact on the shifting of risk between plans and providers. With this adjustment in place, the expected resource needs of a patient population can be anticipated and payments rates adjusted based on their health status. CMS now evaluates the health status of plan populations and risk-adjusts Medicare Advantage premiums to reflect each enrollee's anticipated health care resource needs. The plans then adjust their downstream global payments to providers accordingly.

The importance of risk adjustment into global payment cannot be overstated. Providers interviewed reported that they no longer need to avoid sick patients under global payment to succeed financially. Because providers can get paid more for taking care of sicker patients and are correspondingly paid less for their healthy patients, they are actually motivated to attract the chronically ill and aggressively manage their care. Health plans, acting as insurers, retain an important role in assuming financial risk.

Key Changes from Past Capitation Models

- Awareness of fee-for-service toxicity
- Quality standards and measures
- Risk adjustment
- Reinsurance through plans
- Limited risk tied to provider capacity
- Information infrastructure
- Provider consolidation
- Product designs with patient cost-sharing
- Patients expect unfettered access to any provider

In addition to risk adjustment, reinsurance is used by plans and providers to limit the risk exposure of extremely high-cost claims for providers accepting global payments. It is not unusual for the cost of an individual patient to run into hundreds of thousands of dollars. In the absence of reinsurance it is easy to see how even one very complicated patient could affect a provider organization's global payment budget. With reinsurance, providers accepting global payments are at risk for only a portion of these costs, with the balance paid by the reinsurer.

In the 80s and 90s, providers found that the reinsurance market did not always make it easy or affordable to meet this need. The providers interviewed indicated that reinsurance is now readily available through the health plans with whom they have contracted for global payments. Some purchase reinsurance outside the plans, and in other cases, provider reserves are adequate to retain all or most of the risk themselves. Typically, providers accepting global payments can

choose from a variety of reinsurance levels offered by plans, depending on their size and ability to assume financial risk. Experts reported favorable comfort levels with both risk adjustment and reinsurance availability.

Hospitals have consolidated and many have acquired large components of primary and specialty physician capacity. Interview subjects saw this as a double-edged sword. On the positive side, hospital integration with physicians creates an opportunity for incentive alignment across the delivery system. In addition, hospitals' access to capital addresses the need for up-front investments in systems and staff needed to improve patient care cost and quality.

On the other hand, the largest component of quality improvement and cost savings from better management is achieved by reducing the frequency, intensity, duration, and readmission of inpatient care. In the current fee-for-service market, hospital executives work to increase margin-generating patient-care services, exactly the opposite of what needs to occur under global payment incentives. When asked how hospitals would change in preparation for global payment, one executive suggested: "They would go to different seminars. Instead of learning to code, they would learn how to make their medical homes work."

Many interviewees expressed serious concerns about the notion of hospital-centric structures for the management of global budgets. Academic health centers (AHCs) were cited as particularly problematic under global payment incentives. Not only did physicians and plans believe that their underlying cost structures were generally high, but significant components of the financial incentives under which they operate are unrelated to direct patient care. For example, research and teaching revenue incentives are likely to be inconsistent with the incentives created under global payment arrangements. AHCs often consider it essential that they offer the latest technologies, which may be hard to adequately amortize under global payment arrangements. AHCs also are often concerned that their population risk attributes are not adequately addressed under the risk-adjustment methodologies used for most global payment arrangements.

Patients have expectations of unlimited provider choice. The backlash to capitation in the 90s was largely due to patients' concerns about plan and provider incentives to withhold care and to their unhappiness with limited choices of physicians and hospitals. This was cited as a major factor in the disappearance of capitation in commercial plans. Some providers in global payment programs responded by loosening their rules on patient movement among primary and specialty providers, improving both patient and provider satisfaction.

While quality information and the potential to align provider payments with quality performance may help mitigate patient concerns about limited provider choice, patients need to be educated that new forms of global payment are not simply a return to capitation. After a few decades of unfettered provider access, this change could require a culture shift. Interview subjects indicated that patients who voluntarily opt into products that create an economic advantage for choosing a more-limited, managed network of providers are more receptive to some of the freedom of movement limitations that these products may entail.

Employers have narrowed their plan choices and have demanded open access products. Providers and plans explained that, relative to the health insurance market of a few decades ago, employees who obtain their coverage through their employer are typically offered fewer plan choices. National employers in particular have migrated to uniform national plan offerings. Because global payment products tend to be more local, national plans are less equipped to offer them. The complexity of administering and communicating multiple, market-specific options is one reason employers moved to uniform discounted fee-for-service–based product offerings. To make fewer plan choices tolerable to employees, employers insisted on comprehensive, open provider networks, which several interview subjects cite as the reason for the demise of commercial capitation.

Assuming the commercial health care market continues to be largely employer-based, employers may have to offer more than one coverage choice to give employees the option of choosing a plan that features global payment models. The possible introduction of insurance exchanges and changing rules for the individual insurance market could enable more individuals to opt into global payment-based products.

Plan designs and self-funding have evolved on a different path than global payment. Deductibles and coinsurance can increase patient sensitivity to service costs, but their introduction into global payment models can be administratively costly and challenging. While global payment models are intended to avoid the type of service limitations of fee-for-service, coinsurance and deductibles require tracking and adjudication of covered services to calculate and collect the patient's share of fees. Administration of global payments for self-funded employers is also difficult. Under global payment models, it is less important that detailed attention is paid to individual claims since the focus is on total cost, but plan designs with patient cost-sharing based on individual services consumed will require ongoing claims adjudication.

Our "more is better" culture has not changed. Important drivers, such as fear of death and the imperative to "do something," dominate our culture and affect patient and provider demand for

care interventions. As illustrated in recent health reform discussions, even attempts to reimburse physicians for their time spent soliciting patient and family preferences for end-of-life care were reinterpreted as "death panels," creating public anxiety about losing control of their care options.

KEY FINDINGS—EXPERT INSIGHTS ON WHAT WORKS AND WHAT DOES NOT

Interview subjects uniformly considered overall incentive alignment around the total cost of care across all constituents to be an essential starting point to meet national health care cost and quality goals. They felt that there were multiple avenues to create these incentives. When asked whether moving to global payment would be enough to solve health care cost concerns, one expert stated, "The U.S. economy is unsustainable under the current model. Global payment would be enough to drive change for quite a while."

But all also indicated that there was more to solving our national health care problems than just improving the payment model. The following ideas reflect their many suggestions for how to avoid pitfalls and optimize global payment.

Patient care suffers in the fee-for-service environment. In the words of one physician, "Fee-for-service creates the opportunity to do inappropriate things due to information asymmetry, just like a cab driver taking you the long way." The prevailing fee-for-service model not only drives unsustainable cost increases, it actually impairs access to high-quality care for patients. Patient care management efforts used by providers under global payment are not available to patients covered by plans that pay these same providers on a fee-for-service basis because these services are not reimbursed in fee-for-service payment models. Fee-for-service patients can experience gaps in care leading to suboptimal outcomes and more-complex care, with more steps or procedures increasing the probability of complications.

Conventional wisdom has suggested that physicians do not pay attention in the exam room to differences in how they are paid. But some providers felt strongly that doctors actually do spend more time with global payment patients, explaining why they do not need a particular drug or imaging study or ensuring that they get in to see the appropriate specialist or best education program, for example. Outside the exam room, resources designed for managing patient care are disproportionately available to patients under global payment. Phone consults, Web visits, provider-initiated outreach calls, home visits, participation in patient education programs, and inpatient admission management are not usually covered and therefore not offered to patients in fee-for-service plans. Other changes that can occur when aligned incentives are employed include the use of more physician extenders (such as nurse practitioners and patient educators),

more attention to patient referrals, better management of appointment frequency, and other interactions that may be used to replace physician visits and improve care quality.

Contrary to old stereotypes about the inferior care provided in capitation, providers feel care is much better under global payment. Several physician leaders also cited improvements in professional satisfaction. Primary care physicians are able to focus on the needs of the patient, rather than the need to maximize services rendered. Some providers indicate that care processes are so much better in global payment that they often feel obligated to use these systems on fee-for-service patients at their own expense.

Global payment models are necessary but not sufficient to reverse unsustainable cost trends. Leaders experienced with the management of global payment models felt that the country could spend 20 percent to 30 percent less on health care without sacrificing, and possibly improving, quality. Even in parts of the country currently delivering care at lower-than-average costs, providers felt there were opportunities for significant savings. One provider executive in a low-cost market predicted that there is more than enough money already in the system to allow providers to live with current budgets for five to 10 years.

Moving from the fee-for-service, "piecework" approach to payment to global payments—based on value instead of volume—is an essential, but not complete strategy to improve the trajectory of costs and quality. In the absence of aligned provider incentives, providers cannot make the investments they need for optimizing patient care for the chronically ill patients that drive the vast majority of the nation's health care costs. But, even if all payment incentives were instantly aligned, there is a large, unmet need for expertise in provider leadership, techniques for management of patient populations, and data infrastructure. Other factors or issues not immediately resolved by a move to global payments include downstream provider reimbursement alignment, expected excess capacity of hospitals and specialists, and patient-driven demand.

Pay for outcomes. Experts predicted that quality measurement and incentives could completely change the way global payment models are viewed, by aligning physician and patient incentives for higher quality. Global payment models can be structured to remove existing economic barriers to the innovations that can improve quality. "It is ideal to link [global payment] with pay for quality to assure the patients' needs are aligned with physician incentives," said one physician executive. "Pay-for-performance is better matched with global payment than fee-for-service." Fee-for-service creates no incentive for physicians or hospitals to concern themselves with whether patients get or stay well; in fact, there is no revenue stream for the health care delivery system when patients are well, other than largely unprofitable preventive services. A focus on

patient care outcomes, combined with financial accountability, would reset the emphasis of the delivery system and move the focus from clinics and hospitals to a broader view of community and public health resources.

In some ways, paying for quality performance on top of global payment is redundant. Generally, if expensive hospital and emergency care is avoided, costs are lower. If complications, infections, readmissions and other adverse outcomes are avoided, costs are lower. Providers under global payment structures clearly benefit from these cost reductions. Combining pay-for-performance on quality and global payment could help focus and accelerate progress on many quality initiatives.

One physician executive suggested that physicians should be measured and rewarded largely on patient satisfaction and explained that studies showed no correlation between increased rates of referrals to specialists and patient satisfaction. An emphasis on patient satisfaction and patient preferences also opens the door to better management of end-of-life care. Physicians and executives provided many examples of how working under global payments has enabled them to invest time and resources into helping patients and their families identify their end-of-life care preferences and to manage care so that these are honored. This kind of attention to patient needs and preferences is not feasible in the current fee-for-service payment environment, they feel. One physician described end-of-life care under fee-for-service as "a catastrophic failure of the system: offering false hope, failure to plan, and failure to address patient abandonment issues."

Focusing on clinical outcomes makes the most sense when there is evidence showing what works to achieve optimal outcomes. This kind of information is rarely available to physicians today. Several physician and plan leaders identified anticipated research on comparative clinical effectiveness as a long-awaited tool that would help to support patient and physician decision-making on care interventions. It was cautioned that the definition of outcomes in these comparative effectiveness studies must be based on long-term patient health status. Some concerns were expressed about the time horizon required before quality improvements show cost-lowering results. The year-to-year nature of patient enrollment and analytics would be improved if extended to allow relationships and results to mature.

A full range of provider structures are operating successfully under global payment. Large, integrated delivery systems are able to work well under global payment. However, since the vast majority of physicians in the U.S. are not part of such structures, conventional wisdom suggests that global payment can at best be applied only to a small subset of providers or that all providers

will ultimately need to become part of such a system. The provider leaders interviewed for this project represented a wide range of organizational sizes and types. Very large, hospital-dominated systems; large multispecialty clinics with and without hospital ownership; mid-sized primary care practices; and IPAs representing very small primary care practices all have found ways to be successful in global payment programs. Some successful IPAs have expanded or are in the process of expanding geographically into new, previously unorganized markets. They are finding that the information and clinical support infrastructures they have refined over the years can be leveraged across a broader physician base.

Much of the quality and cost improvement that can be generated through global payment is obtained by avoiding admissions. This dynamic creates opportunity for physician-led organizations but presents challenges for vertically integrated delivery systems. Similarly, narrowing referrals to a subset of specialists either through selective contracting or practice pattern preferences was considered by physician leaders to be a key feature for successful primary care patient management under global payment. Large, integrated delivery systems do not have this latitude and in a market still dominated by fee-for-service payments, the best admitters to hospitals are often the very specialists that would be starved under global payment.

Conversely, the longer-term potential for better patient management across the continuum of care may be greatest in integrated delivery systems once incentives are fully aligned. They have access to capital to invest in the changes that need to be made, while smaller, physician-driven organizations have needed to self-finance these investments. Primary care-driven systems are in no position to take overhead costs out of hospitals, generally are not well positioned to negotiate aggressively with other providers, and cannot drive electronic integration across the full continuum of care.

There were many similarities in methods used to manage patient care and cost for large and small provider organizations, although each approach was tailored to the specific needs and capacities of the providers they represented. Information and analytics were essential to care management for all provider types. Management of admissions and generic drug use was central to all providers. New approaches to “between-visit” care formed the core of techniques to improve outcomes and reduce costs. Use of support teams and physician extenders was common to all provider types, although there were nuances in how they were used. All provider organization types seemed to struggle with downstream provider payment alignment to some degree.

Types of Provider Structures Accepting Global Payment

Integrated delivery systems: Large, commonly owned provider organizations that can provide all or most of the continuum of patient care needs within their own walls. Allina Hospitals and Clinics and Park Nicollet Health System are examples of integrated delivery systems and were interviewed for this project. In these systems, there are a variety of downstream payment structures for individual physicians, ranging from salary to payments based on the quantity of services delivered or the number of patients under care.

Independent physician associations (IPAs): Umbrella organizations that provide a range of services to multiple, smaller, or solo physician practices. Some include primary care physicians only, others also include specialists. Monarch Healthcare and Healthcare Partners are examples of IPAs and were interviewed for this paper. Each of these organizations represents up to 1,000 primary care physicians in hundreds of offices across southern California. Physician Health Partners, also interviewed for this project, is an IPA in Colorado, with nearly 300 primary care physicians in more than 100 locations. In many cases, participating physicians belong to more than one IPA and may be part of multiple global payment arrangements through these IPAs. Often these physicians are paid on a fee-for-service basis with a potential bonus based on global payment performance metrics, which usually include patient satisfaction, quality, and cost measures.

These organizations arrange for or provide all of the services that these small practices need to be part of a global payment arrangement, including:

- negotiating global payment contracts with health plans;
- contracting for the full range of patient care services, such as specialty care, hospital care, durable medical equipment, etc.;
- collecting and evaluating financial and clinical data to evaluate and improve performance;
- aggregating reserves to smooth risk assumption;
- providing clinical care and case management support for chronically and catastrophically ill patients; and
- managing hospital admissions and expediting discharges.

Single specialty and multispecialty group practices: This category includes groups of physicians that do not own hospital facilities and typically do not include specialists or have only a subset of the full range of specialists within their organization. For this paper, New West Physicians in Colorado, with 48 primary care physicians, and Atrius Health in Massachusetts, with five separate large group practices with nearly 1,000 physicians, represent this provider structure.

These organizations work to deliver the same functions as outlined above for IPAs, but generally are able to exert more control over the individual physicians and the organization of their practices. Individual physician payments range from salary to pay for services delivered to payment based on the number of patients under their care. Bonuses or penalties for quality, patient satisfaction, and cost performance are common.

In many ways, smaller practices and IPAs have moved further forward in the management of patient care in innovative ways. The ability to be nimble, coupled with not being required to serve the conflicting interests of multiple constituencies, streamlines decision-making and enables progress. In addition, without the burden of enormous investments and debt for physical buildings and extensive management infrastructures, these smaller organizations can often perform at a lower cost.

The move to global payment models needs to be transitioned. Because payment alignment is only the beginning of the solution and will take time to bear fruit, experts recommended that a multiple-year transition strategy commence as soon as possible. Some predicted that rapid change would occur once incentives are changed. In fact, experts expected that care delivery changes will start to occur even before the actual implementation of the change in payment as long as the providers know with some degree of certainty what future changes will be made.

Interview subjects advised that this transition period should encompass changes in both payment models and provider structures. During this period, provider and patient education should be deployed, and investments made in technical and infrastructure support. Realistic timetables for phase-in are important to allow for an orderly transition. Potentially damaging disruptions, from a rush to ill-informed consolidation to shake-ups in municipal bond markets, could be minimized through careful transition planning. Excess capacity created through improvements in quality and resource use will take time to be repurposed or absorbed and financial structures to support this transition should be considered. For example, as hospitals generate excess capacity, revenue may be inadequate to cover overhead that was formerly spread across more services. Several experts suggested that making transitional payments, which would decline over time, to help cover marginal operating expenses as capacity is repurposed or absorbed could make the transition smoother.

A well-articulated transition plan would help providers organize and prepare, and would also enable commercial payers to build on Medicare approaches. It is essential to delivery system change that a critical mass of payments follow similar incentives, even if not all payers get there at once or in exactly the same way. Current commercial efforts to move to global payment arrangements are hampered by uncertainty about the future direction of CMS, the country's single largest payer.

Paying provider entities for patient care can be accomplished in a variety of ways, as long as incentives for management of cost and quality are pervasive. Experts suggested that a range of approaches should be designed based on provider organizational structure, size, readiness, and capacity for risk. Different levels of risk should be allocated to provider groups as appropriate to their size and sophistication in management of patient populations. "Full global payment risk should not just be dropped on providers," stated one subject. It should not be assumed, nor was it considered necessary, that every provider would ultimately make it to the "final" step along the global payment continuum. Instead, several intermediate levels of risk-sharing should be supported indefinitely with incentives to move to greater assumption of risk.

The transition strategy should not anticipate that all providers will eventually arrive at the same end point; some provider organizations are likely to move to higher levels of risk assumption over time. In no case should individual physicians be at full risk for their patient populations. Several interviewees stressed that upside-only risk is not effective and global payment arrangements must include the possibility of penalties.

It is important that global payment models include both cost and outcome accountability. Without this accountability, incentives may reduce cost, but may be less effective in improving outcomes. Experts felt that outcome measures should be broad-based and best focused on maintenance or improvements in patient function and response to care interventions, rather than on compliance with care process measures. Providers indicated that successfully managing under a global payment model is really more about managing patient morbidity risks than about managing cost.

Increasing Degrees of Risk Under Global Payment

- Revisions to current CMS payment amounts to better compensate cognitive services and compensate less for procedures
- Payment for care management fees to medical homes and providers managing chronically ill patients over time that are tied to care quality improvements and cost reductions
- Opportunities for providers to earn higher-than-average fee-for-service levels based on cost and quality performance
- Bundled payments across provider types for certain types of care episodes
- Nonpayment for readmissions and treatment-acquired complications
- Programs with opportunity to gain share on top of fee-for-service
- Programs with shared risk with limits on up- and downside risk
- Limited gain share, such as bonuses, in addition to fee-for-service payments
- Provider-held risk for all services against agreed-upon targets

Cost and quality performance should consider adjustments for population differences. Old models of capitation did not account for differences in patient illness burden, leading to patient and provider concerns about caring for sicker patient populations. Participants encouraged the idea of increased incentives for the care of the very sickest patients because these cases can generate the biggest outcome and cost improvements.

With a range of payment alignment approaches in place, provider groups of all kinds—small and large, urban and rural, fragmented and integrated—can participate as long as the degree of risk exposure is set consistently with the provider's risk tolerance.

Some of the infrastructure now in place to manage existing programs is either already expanding geographically or is considered expandable. There were varying opinions about the optimal size of a provider organization for purposes of managing patient populations and assuming risk. Although global payment arrangements can be structured to enable smaller providers to participate, some experts pointed out ongoing disadvantages of fragmented providers and suggested they become part of larger provider organizations that have "access to the analytics and process improvements befitting a modern enterprise."

Increasing consolidation should be anticipated. As said by one expert, "Too much provider consolidation in accountable care organization markets will cement costs and market concentration." Another provider executive added, "Local, small, and nimble provider organizations are best positioned to drive change quickly." A broader move to global payment will likely drive consolidation and have positive and negative consequences. Many providers felt that the collaboration and incentive alignment needed to perform well in global payment models could be successfully accomplished through virtual rather than vertical integration. In fact, some indicated that independent providers can and often do actually outperform more-integrated providers with the right support, tools, and incentives.

Vertically integrated provider organizations require a great deal of overhead that can be avoided in smaller organizations. In addition, vertically integrated provider organizations tend to keep as much care as possible within the organization, even if that care is available at a higher quality and lower cost externally. In some cases, antitrust and Stark anti-kickback laws make virtual integration challenging and should be amended to better enable innovation in these structures.

Experts also felt that much consolidation was more about competition avoidance and market protection and not truly designed to improve care delivery performance. It was pointed out that in one market, the plan and provider oligopoly situation was very comfortable for both. The experts were concerned about the relative absence of the Federal Trade Commission (FTC) in preventing anticompetitive consolidation and cautioned that an increased presence would be necessary as incentives around global payment become more prevalent.

Gaining provider interest and acceptance. Most providers now organize around fee-for-service incentives and maximize higher-margin services and minimize lower-margin services. It may be unrealistic to expect changes to these structures to occur voluntarily or quickly.

In the past, there were many devastating, high-profile failures of providers managing capitation payments. While improvements are now in use, such as risk adjustment and tailoring risk to the provider's capacity, it is reasonable to anticipate that many providers will hesitate to voluntarily accept any degree of accountability for cost and quality.

Experts suggested that it makes sense to make fee-for-service reimbursement less attractive, while making risk-sharing in global payment models more attractive. Therefore, it would be useful to reduce prices paid under fee-for-service reimbursement while offering relatively more attractive global payment options.

Providers need a critical mass of patients under global payment models. Optimizing resource use and patient outcomes requires different investments and staffing than does fee-for-service medicine. Mixing global payment patient populations with fee-for-service populations creates conflicting incentives and limits provider innovation and changes in investment strategy. With a critical mass of patients under a global payment model that rewards cost and quality management performance, providers can make radical changes and apply new resources to improving patient care.

Incentive consistency can be achieved in multiple ways. Providers would generally prefer administrative streamlining, simplicity, and standardization, but acknowledge that not all payment arrangements must be identical to be effective. A combination of aligned, but not identical, payment structures can be used to drive the necessary investments to improve overall cost and quality performance.

Providers and payers in Boston and Minneapolis specifically suggested the use of variable fee-for-service payments based on overall cost and quality performance. This approach has effectively aligned incentives for them while using the existing fee-for-service claims payment infrastructure. In this model, future fee levels are raised if performance against a global payment target is positive and lowered if negative. There are no retrospective financial reconciliations. This model has worked well for self-insured employers who are at risk for their own claims costs and can be effectively combined with high-deductible and coinsurance-style plans.

Medicare participation is absolutely essential to reformed payment. Medicare payment has, by far, the biggest impact on provider incentives. Medicare reimbursement policies drive the business models of physicians and hospitals; they typically make capital investment decisions based on the payment structures and amounts they can expect from Medicare. Medicare fee levels for physician services (current procedural terminology, or CPT, codes) and hospital services

(diagnosis-related groups, or DRGs) determine what services are profitable and which lose money for providers, locking providers into a set of activities based on margins, not patient needs. If Medicare payments encourage overuse, as they do currently in fee-for-service plans, providers respond by increasing the supply of profitable service lines, the use of which flows to both Medicare and commercial patients.

Plan and Provider Suggestions for CMS

- Send clear messages about movement to global payment
- Broaden Medicare demonstrations and pilots
- Enable regional flexibility; innovation cannot occur nationally
- Create steps along the global payment continuum
- Focus quality metrics on health status outcomes
- Address geographic disparities
- Evolve value-based benefit designs
- Work on patient and provider culture change

The providers interviewed for this paper who currently accept global payments do so for all or part of their Medicare populations, but typically not for commercial patients. Some providers stated that they will not care for senior patients covered by Medicare fee-for-service plans. Even if all nongovernment plans were organized around global payment models, the absence of aligned incentives for Medicare patients obstructs realignment of capital investments and innovation around patient care. Also, in commercial populations there are fewer predictable opportunities to better manage care because of the different care needs of younger populations. Inpatient use rates are much lower, though some experts identified significant opportunities to improve quality and resource use in areas such as maternity and chronic illness in the 45-to-64 age population. However, many health care needs of commercial patients are more acute and time-limited. Cost and quality of these types of services can also be improved, but are more difficult to manage than longer-term, predictable chronic illnesses and end-of-life care.

Because the needs and costs of Medicare patients are so great, particularly with respect to chronic illness, managing this population has the greatest opportunity to improve value. Chronically ill and terminally ill patients can benefit from patient-centered, proactive care that is consistent with their preferences, improves outcomes, and reduces cost, but payment limitations in fee-for-service Medicare restrict the availability of primary care time. Several providers specifically identified the management of end-of-life care as a strategy that provides better outcomes and greater satisfaction for seniors and their families. New models of care and integration of care into the day-to-day lives of seniors were also identified as possible, with the right payment incentives. These changes become even more necessary as the population ages.

Episode-specific bundled payments can be a part of payment reforms but should not stand on their own. The introduction of bundled payment models is a positive but limited step to a better payment model. Most experts thought bundled payments would work best as a component within an overarching global payment model. Better incentive alignment across physicians and hospitals was seen as highly positive and as a step to initiate constructive dialogue among parties that do not currently collaborate effectively. Bundled payments could be especially useful in raising awareness among provider clusters about what things cost and how providers can better work together to improve cost and quality. For bundles that involve procedures, the opportunity to engage specialists also was seen as very advantageous. Most experts could see bundled payments as a useful step forward on the payment spectrum, but had many concerns.

"Episodes are attractive, but hard to define. There are many opportunities for gaming, and there is an incentive to do more episodes. These payments work best for systems, but three-fourths of physicians are in small practices," one subject said. Another physician cited concerns that "Episodes are not mutually exclusive. This type of payment has some value, but it's still just fee-for-service with a different unit." As one payer put it, "There is nothing to determine episode necessity, these payments don't embed quality yet, they are provider-centric rather than patient-centric, there is a space between episodes, and there is not an incentive for episode avoidance."

In addition, there were concerns that episode-type payments cannot trigger enough change to force reengineering; therefore they cannot drive right-sizing of capacity. To the extent episode payments are hospital-centric, physicians had issues with the locus of control and the ability of hospital leaders to use them to improve value. One physician leader said that at a recent hospital-organized meeting on this topic, "There was no discussion on how to reorganize care, just a fight about how to split up the money." Other issues with bundled payments were repeatedly raised, including the lack of patient-centeredness because of the splitting of patients into a series of bundles and the potential for multiple overlapping bundles for a single patient. Others expressed concerns about fuzzy boundaries regarding determining what care is inside and outside the bundle, and the need for very specific appropriateness criteria.

Sufficient lead time to learn how to work with bundled payments was strongly recommended. There is much to be learned about how to determine which providers to hold accountable for which patients and how to redistribute dollars among providers who participate in an episode of care. The infrastructure and governance to manage care episodes does not yet exist and will need to be developed. But as one provider put it, "Episodes are half a loaf. They are better than fee-for-service and most learning occurs by error."

The amount of payment as well as the form of payment is critically important. As one expert explained, "If the price of the capitation is controlled, then capitation can control cost." Global payment models can introduce aligned incentives, but there is still a need to control the overall budget.

Global payment requires the establishment of a "target," or budget, for health services spending. Several interviewees discussed how, in other countries, overall budgets, payment levels, or prices are set by the government based on how much the country is willing to spend on health care services—an explicit acknowledgment that resources for health care are finite. This limit does not exist in the U.S., so global payment budgets are subject to negotiation between plans and providers. There was skepticism that the market alone could discipline the rates of global payments or equalize the variation in costs across the country; however, some providers now operating under global payment models are aware of external economic pressures and have tempered their negotiations for increases in global payment amounts.

While Medicare Advantage premiums are established by the government, provider global payment targets for Medicare patients are jointly established by plans and providers in a variety of ways. Target costs for providers under a global payment model involving Medicare products are often negotiated as a percent of the total premium amounts that are established by CMS. Target-setting processes present opportunities to tailor the type and amount of risk that providers hold, but also introduce clout-based negotiations that favor more powerful provider organizations and plans. The share of premiums that flow to the provider can vary from provider entity to provider entity for the same plan, and the same provider may have different premium percentages from different plans. These negotiations involve more than the amount of the global payment. Inflation rates, reinsurance thresholds and costs, degrees of risk-sharing, reinsurance levels and cost, carve-outs, funding of bank accounts, holding of reserves, data sharing, and performance of administrative functions are all material components of global payment arrangements.

Methods of establishing global payment most commonly fall into three general but overlapping approaches:

- **Negotiated global payments amount.** Historically, the establishment of targets between plans and providers was adversarial and in some markets routine contract terminations in anticipation of contentious negotiations were the norm. Providers and payers indicated that these negotiations have generally evolved toward a more win-win, long-term approach based on community goals using more transparent data. Payers acknowledged that their past expectations that providers could immediately bring down costs may have been

unrealistic. Providers could not change fast enough and an expectation of immediate cost reduction did not account for the investments that had to be made to get there.

- **Historical provider-specific cost of care for patient populations.** As one subject observed, "It is not realistic to come in and expect to immediately cut payment to big players. While using historical costs may not be the most rational way to set rates, it may be necessary to inject an investment into moving providers into global payment." Some plans are adding extra incentives for better performance on quality metrics. Over time, higher-cost providers can move toward market norms by controlling the rate of growth, so that there is a greater allowance for increases in cost for the providers starting out more efficiently.

- **Percent of Medicare Advantage premium.** Some providers have their targets established as a percent of Medicare Advantage premium paid to the plan. The actual percent of premium and the areas and degree of shared risk are negotiated between the plan and provider. When Medicare Advantage premiums increase or are adjusted up or down to reflect the risk mix of patients, those changes flow through the plan to the provider.

All experts interviewed for this paper reported concerns with the basis for global payment negotiations. In most cases, providers are not advantaged by agreeing to lower target amounts, so they have incentives to maximize their global payment amount. The incentive for the plan is to attempt to minimize the amount of the targets, but powerful provider organizations are able to negotiate higher targets and more favorable risk-sharing arrangements. This often leads to the need for plans to negotiate more aggressively with less powerful providers to meet their overall financial needs.

This approach to global payment negotiation encourages provider consolidation to achieve clout, as much as for clinical integration. Interview subjects identified circumstances where consolidation can be helpful, such as vertical provider integration that aligns incentives across the continuum of care, but were concerned about horizontal consolidation that limits competition. They expressed frustration regarding the lack of antitrust intervention for the providers and plans that have already consolidated. Quite a few experts questioned the absence of FTC limits on past consolidation and suggested it would be critical for the FTC to engage in ensuring that market power does not become even more excessively concentrated as global payment models proliferate.

Suggestions for making providers more sensitive to holding down their level of global payment include the introduction of a "gas-guzzler" type excise tax on providers who require above-market global payment amounts and the introduction of consumer incentives to use providers with more competitive global payment levels, using tiered or value networks.

Because of geographic disparities in Medicare premiums, in communities with higher premiums there currently seems to be more than enough money for plans and providers. In some geographic areas, margins from Medicare business actually subsidize losses in commercial business. Even in communities with lower Medicare premiums, providers felt there was so much opportunity to reduce waste and improve resource use for seniors that current global payment levels would be adequate for some time to come.

Suggested Improvements in Global Payment-Setting Methodology

- Regional equity
- Incorporate payment for outcomes with global payment
- Reduce future increases in global payment amount
- "Gas guzzler" excise tax for providers with above-market global payment amounts
- Introduce consumer transparency and incentives
- Base global payment amounts on overall community-wide or national spending targets

It was widely anticipated that the CMS premium payments to Medicare Advantage plans will be revised downward in the future to be more consistent with the cost to manage other Medicare populations. If that occurs, providers and plans may feel squeezed on the amount of premium available to share, leading to more challenging negotiations about global payment levels and risk-sharing. This potential volatility in government payment streams is a problem for both plans and providers who have identified the need for more rate stabilization over time. Others felt strongly about reductions in geographic premium disparities over a reasonable time frame.

Some of the plan executives and provider leaders saw establishment of global payment targets as becoming more of a long-term partnership between plans and providers, with one plan executive describing their strategy as "shaping trust over time largely through the use of transparency." Experts cautioned against moving too quickly; moving forward without good, shared data; and the need to engage in ongoing bilateral discussions.

The implicit objective of paying all provider organizations the same (risk-adjusted) global payment amount was questioned. Some experts felt that the goal should not be uniformity of costs, but to give consumers the choice of provider at varying cost levels, to create societal pressure on providers to hold costs down. Opportunities to gain market share when provider organizations could deliver at lower costs was identified as a market-based vehicle to hold costs down.

Measuring financial success under global payment models is challenging. Most often, in the absence of any other available benchmark, providers compare how much they would have received under traditional fee-for-service payments to how much they received under global payment. Some global payment arrangements are based on cash flowing claims using a fee-for-service payment structure. Fee-for-service levels are typically used to determine how global payments are allocated among different provider components that are working together under a global payment target. Using fee-for-service as the underlying yardstick for cost performance evaluation perpetuates the need for filing and adjudication of claims, with corresponding high transaction costs and the continued distortion that emphasizes procedures over cognitive services. As global payment becomes more prevalent, better ways of assessing the real cost of resources used and avoidance of added transaction costs incurred, such as micromanagement of claims, need to be developed.

Downstream Provider Alignment and Payments

Payment formulas to individual physicians within the provider organization and to specialty physicians and hospitals outside the organization need to support the incentives under global payments. Physicians control the vast majority of health spending decisions, so it is critical that their individual incentives are aligned. Hospital investment and organization decisions are driven by their incentives, so they also must be aligned.

Frequently, individual physician compensation is based mostly on units of production (the number and intensity of visits and procedures they deliver). This works well in a fee-for-service world, but is completely counterproductive under global payment. Payment methods that work better in a global payment environment include: payment based on salary, panel size (the number of patients under their care), patient retention, performance on quality and patient satisfaction measures, and bonus or penalty based on organization-wide performance on global payment targets.

Physicians in independent practices that participate in global payment are often paid based on the units of service they provide coupled with a bonus or higher fee levels based on individual and organizational performance. Several plan and provider experts emphasized the need for penalties, as well as bonus opportunities, to achieve sufficient focus on the part of physicians. Even when payments are aligned it has been difficult for some providers to educate physicians on the incentives under which they are working. Others providers have succeeded in translating incentives downstream, with physicians receiving fully transparent information about their own and their peers' performance on cost and quality metrics.

The balance of risk at the individual provider level is important and one expert cautioned against creating such strong incentives that things like "spot pricing" (i.e., directing patients to the provider who is cheapest at any given time) for specialty and hospital care are encouraged over care quality and continuity. Care and referral decisions should be aligned over a longer time horizon to prevent unstable relationships and discontinuities of care. Creating the right balance of incentives along the care continuum has been an ongoing challenge for most of the providers interviewed for this paper.

Innovations Under Global Payment: Example

A provider organization described a unique approach to the development of a cancer care consortium. It was made up of a virtual team of eight to 10 specialists, including oncologists, radiation oncologists, surgical oncologists, and palliative care specialists, and led by the primary care physician. From the consortium, recommendations are gathered and reviewed with the patient and family by the primary care physician, usually jointly with the lead oncologist. Team members use national guidelines to inform their recommendations. Patient care plans are discussed and agreed upon. As a result, patients feel informed and aware that they have choices. The practice indicates very high patient satisfaction, better outcomes consistent with patient preferences, and significant cost savings.

In particular, ideal incentive alignment with outside specialists has been difficult. Competition among specialists is limited in many markets. Interview subjects use a range of payment models ranging from fee-for-service to case rates to subcapitation, but did not generally feel any of these arrangements worked perfectly. Several experts recommended that fee-for-service payments for specialists be scaled back over time and replaced with bonuses for quality and cost performance.

Today, specialists' lack of critical mass of patients under global payments limits the strength of the incentives. Some providers expressed concern about horizontal consolidation within specialties leading to reduced competition. In these cases, providers generally are compelled to contract with an entire practice, but may specifically steer their patients to a smaller subset of specialists with whom they have better working relationships. Some felt that specialists will need to see material reductions in patient volumes before they turn more of their attention to better management under global payment incentives. There is a growing trend toward specialty practice acquisition by hospitals. As one expert suggested, this creates the opportunity to have specialists employed by the hospital (health system) and paid a salary and bonus based on individual and organizational performance, assuming the hospitals are aligned through a global payment mechanism.

New Leadership and Relationship Skills on a Local Level

As one subject explained, "Current provider and plan leadership is selected based on their ability to *stop* change." The importance of visionary leadership and strong provider governance was frequently cited by interview subjects. Physician leaders who can articulate a vision around cost

and quality improvements in patient care, hospital leaders who see a new economic model for their institutions as cost centers and not profit centers, and health plan leaders who move from win–lose provider negotiations to long-term provider partnerships based on mutual success were identified as instrumental to an improved health care payment and delivery model. Interview subjects expressed concerns about the ability of many, but not all, current leaders to demonstrate these skills.

Health care is local and thrives on local relationships. Many providers who have built high-performing systems maintain a local focus and emphasized the value of their relationships. Interview subjects repeatedly cited relationships as core to success, including relationships with constituent physicians, long-term trusted relationships between patients and physicians, and constructive working relationships among primary care and specialty physicians. Fewer positive relationships and quite a few negative relationships with hospitals were identified. The plan–provider relationships that currently exist were generally described as much improved by both parties, though there were aspects of mistrust that cropped up in a number of interviews. Providers with contracts that included both local and national plans clearly preferred working with locally based, regional plans. Providers often cited the lack of decision-making power of the national plans' local employees and expressed frustration with the innovation-dampening effect of needing national plan support for local initiatives. This finding suggests that standardized, nationally imposed approaches to global payment may be problematic. The right-sizing of community resources that should result from aligned global payment incentives can only occur locally.

Shared accountability among providers for patient outcomes and quality also made the most sense at the local level to those interviewed. High-performing provider organizations often relied on complete performance transparency as a powerful management tool. Provision of this level of information needs to occur in a trusting environment, where the focus is on improvement rather than challenging data credibility. The power of these data to drive change increases when results are shared among the provider's immediate peers. A few interview subjects indicated this level of transparency was a barrier to recruiting new physicians who were uncomfortable with this degree of accountability. Increased performance transparency across all physicians in all payment models could help reduce this barrier to recruitment.

Provider organizations described innovative, highly effective approaches to improved management of chronically ill and frail elderly patients that require extensive, hands-on primary physician involvement in both patient relationships and specialty physician relationships. These innovations rely heavily on physician leadership and willingness to test new approaches. The

economics of global payment models can enable this kind of activity, but without additional time and energy commitments from physician leaders they cannot occur.

Several experts highlighted the importance of physician education in the successful operation of global payment models. These experts assert that demand for health care services is largely physician-driven and in the absence of education about the cost and value of services physicians cannot push toward higher value levels.

Global Payment Models Will Require Hospital Transformation

Interviewees lamented the current "putting heads in beds" management strategy that prevails among hospital management teams, although many could also identify more visionary hospital leadership in their communities. Currently, payment incentives for hospitals reinforce this bed-filling strategy for hospitals that are less than full. Once patients are admitted, some physician leaders commented that proactive management of admitted patients helped the hospitals manage patient length of stay enough to enable margin generation on DRG payments, something the hospitals had not been able to achieve without the direct involvement and alignment of admitting physicians.

The demise of a number of previous capitation arrangements was linked by some subjects to financial losses incurred by participating hospitals. In some markets, it was typical for hospitals to assume a substantial part of the financial risk, yet they were unable to successfully manage the physicians who were their biggest admitters since many of these arrangements held no downside risk for physicians.

Repeatedly, physicians raised fears of emerging bundled payment and accountable care organizations that are organized around hospitals. In reference to the ability of hospitals to revise their strategies, one subject said, "They just can't help themselves." The concern is that hospital-centric models cannot drive the patient care changes that are the backbone of cost and quality improvement. As one subject put it, "Global payment . . . puts physicians at the center. Everything else is a resource to *them*." This change in physician role underscores the less-than-ideal structure of putting hospitals in charge of payment allocations. Doubts were raised about the ability of hospital executives to completely change direction in order to manage patient populations under global payment.

Much of the cost saving generated through improved management of patients comes from admission avoidance. Typically, hospitals have no experience with this type of care management nor are they in a position to make changes that rely on physician behaviors. In a fee-for-service

environment, hospitals that employ physicians are actually motivated to limit the effectiveness of admission controls. It was suggested that the experience hospitals are now starting to gain in dealing with CMS nonpayment for 30-day congestive heart failure readmissions will be an excellent learning opportunity. Physician leaders who were interviewed acknowledged that hospitals may well be the only entity available to lead new global payment initiatives in markets where physicians have not been organized or do not have sufficient capital.

Organizations that have been successful with global payment have reduced both specialist and inpatient service use and predict that widespread adoption of global payment models will result in significant excess capacity of hospitals and certain specialty types, a problem that must be addressed. For hospitals, services that were profit centers instantly become cost centers under global payment. Some interview subjects predict swift changes in resource allocation once economic incentives are realigned. Several experts advised a slower and more careful transition period to avoid precipitous change and disruption. One expert advised that if most of the savings come from reduced hospital use, some of those savings need to go to the hospitals to support their transition. Many hospitals are already scaling back on capital expenditures because of economic pressures and limited access to capital. An awareness of impending changes in reimbursement incentives, even if they will not be implemented for some time, will inform current hospital investments, allowing them to make better long-term decisions.

These incentive changes are particularly challenging for academic health centers, even if a critical mass of their clinical services are in some kind of global payment arrangement. In addition to payment for clinical services, these centers generate substantial revenues through research initiatives, patents, and tuition. Competition for students and professors requires them to elevate their reputation for high-tech facilities and expertise.

Rising tensions between doctors and hospitals can be expected to occur once the size of the financial pie is limited. All parties will ultimately be required to think of themselves as parts of integrated delivery systems—a process that will take years to evolve.

The Evolving Role of Health Plans

Moving the entire provider market to global payment models would result in changes in the role of health plans. Some providers questioned the need for plans at all and speculated that downward pressures on Medicare premiums will force plans to exit the business, while providers are left to seek new avenues to fill resulting gaps. A few providers mentioned that they have or are considering licensure to step into the insurer's shoes as full risk-taking entities. Several provider

leaders indicated they are considering benefit arrangements and products where they bypass plans and contract directly with employers.

Most providers interviewed see an ongoing role for plans, but had issues with perceived redundancies and excessive overhead. The role that plans have played in carving out services was considered counterproductive by some interview subjects; eliminating that approach was seen as a positive step. Providers were especially dissatisfied with respect to plan-based, patient-care management. Neither plans nor providers were happy with current approaches to establishing global payment rates and risk-sharing arrangements. Plans expressed concerns based on past provider failures that provider organizations under global payment models need significant oversight.

While both plans and providers believed that less plan involvement in care-management activities was preferable, plan leaders pointed out that provider organizations vary greatly in their competency to care-manage and felt plans must play a critical care management role for some patients. While providers with global payment experience generally did not value plan-based, patient-care management activities, there were suggestions that plans could play a valuable role in helping employers create healthy environments and in wellness and health improvement activities for enrollees.

As incentives are aligned under global payment models, the plan leaders who were interviewed expect to provide supportive services to help providers succeed. Examples could include staffing and protocols for patient coaching, care management, preventive reminders, and medication management. In this structure, plans could essentially private-label care management activities on behalf of providers, even placing plan employees on site, working directly with providers. Another plan role could include helping providers with supporting data analytics and reporting. Risk-pooling, risk-sharing, reinsurance services, and other financial accounting and claim dollar dissemination roles could also add value in global payment environments.

There was considerable discussion about other changes in the role of plans. Creation of new products that align patient incentives and direct volume to better-performing providers is another important plan role. Plans can also add value by helping patients learn more about the value and cost of health care interventions

“Enlightened plans,” said one subject, “could accelerate new financial models with creative ways to protect smaller provider groups from too much risk.” This type of plan role could include creating different models of risk, creating tiered network products, and funding

or financing investments in provider management infrastructure. Some providers indicated that paying claims and selling reinsurance were functions readily available outside of health plans. However, having reinsurance at various funding levels available to providers was seen as an important role for plans. Several interview subjects suggested there should be regulation of the degree of provider risk-taking. Several suggested not all plans are likely to survive in the long run.

When provider organizations have moved from fee-level negotiations to global payment contracts with plans, questions arise about how to organize and collect supporting information. Some plan executives and providers identified the value of community-wide quality metrics, algorithms to determine provider performance, risk adjusters, and other measurement activities. Plans could have different payment approaches as long as the incentives are consistent, and they would not need to have the same payment rates and products. One plan executive felt that plans could create value by forcing down fee-for-service contract rates to accelerate provider acceptance of global payment contracts.

Among current global payment arrangements, there are many variations in the allocation of claims processing and downstream provider reimbursement duties between providers and plans. Some providers have taken on this role, in large part to stay closer to the data, which they use extensively in their patient and provider management activities. While plans and providers both report a much higher degree of data-sharing from plans to providers than in earlier capitation days, several providers expressed concern about the accuracy and timeliness of these crucial data. Providers felt that data asymmetry was still an advantage to plans in the negotiation of global payment targets. In most cases, plans have access to more complete data than is available to the provider. Several experts identified performance transparency and benchmarking as important stimulants to quality and cost improvement and felt plans could play an important role in that effort.

There are a variety of arrangements between plans and providers with respect to behind-the-scenes operations of global payment models. Some plans prospectively deposit all or part of the global payment into the bank account of the provider and draw on this to pay costs incurred outside the provider organization. In some cases these funds are held by the plan and gains or losses are shared retrospectively. In some global payment arrangements, contracts with specialists and facilities outside the globally paid organization are secured by the provider group, and in some cases these contracts are negotiated by the plan.

In a market dominated by global payment, plans will have the important role of designing and deploying a variety of reimbursement models that are directionally consistent, but flexible enough to meet the needs of different types of providers and provider organizations. Creativity and flexibility in developing and implementing different approaches to payment will be important to their value proposition. Collecting and disseminating payments for health care services is an important role. Among the plans and providers interviewed there was no consistency in the way risk was shared, global payments were banked and funded, claims were collected and paid, and how data were shared. There were preferences for a variety of approaches to global payment with some favoring banking of the entire budget by the provider entity at risk. Some experts encouraged prospective global payment pool adjustments. They cautioned against too much reliance on retrospective reconciliations, but instead recommended prepayment for primary care services only with the ability to cash flow other providers on a variable fee-for-service payment. Providers seemed open to working under global payment arrangements with different details in the way payment is administered and risk is shared, as long as all their contracts shared common incentives to manage the total cost of care. Plans could lead efforts to achieve community-wide uniform data and quality measures to standardize and streamline data transmissions and bring administrative efficiency.

Another growing role for health plans is encouraging employer support for activities to maximize employee health. Providers felt they are well positioned to relate to their patients on health care interventions, but that overall employee wellness and productivity-enhancing activities have not been part of their purview.

The providers interviewed had many ideas and examples of care innovations that can occur under the right incentive alignment. While providers felt these types of innovations must be provider-led, plans could provide behind the scenes organizational and financial support and benefit alignment. Plans are seen as having access to capital that providers, particularly primary care providers, do not. It was suggested that plans invest in developing and testing innovations that could ultimately be deployed more deeply into the provider community. One interesting suggestion was for plans to develop a prototype physician practice that would deliver concierge-type care for the frail elderly (i.e., helping patients meet a broad range of needs including those not typically available through care providers like transportation, meals, cleaning), enabling physicians and their teams to focus intensely on the care management and care planning for high-risk patients.

Examples of Typical Global Payment Structures

	Integrated Delivery System (IDS)	Independent Physician Organization	Old Style Capitation
Entity accepting risk	Large, multispecialty group practice with hospital	Umbrella organization of independent primary care small group practices	Individual physician or small group
Services included in global payment	All covered services	Full risk for primary care services Shared risk for specialist and inpatient services No risk for pharmacy No risk for mental health services No out-of-area or out-of-network services	All covered services
Risk-limiting approaches	Claims for any patient in excess of $100,000 paid by plan Global payment amount fully adjusted to reflect patient illness burden Full risk assumption	Claims for any patient in excess of $50,000 paid by plan Global payment amount fully adjusted to reflect patient illness burden Risk limited to +/– 10 percent of fee-for-service equivalency	Reinsurance only available through outside market No adjustment to reflect higher expected costs of sicker patients Full risk assumption
Funding of claim accounts and reserves for future claim payments	Part of funds held by provider organization and part held by plan for pharmacy and other claims outside IDS. Provider organization carries reserves for unpaid claims.	Claims are cash flowed as incurred, with reconciliation based on actual performance. Payer maintains reserves.	Prepaid budget amount. Unregulated, often little or no reserve maintained.
Incentives for quality	Bonus paid for high performance or improvement on quality metrics	Bonus paid for high performance or improvement on quality metrics	None

Economic alignment with patients would improve opportunities for patient advocacy and overcome patient suspicion. In the words of one expert, "American patients believe that money is no object [when it comes to health care]. In England, the public understands that there is a limit to public money." Another interview subject added, "Patients believe that more care is better care. In fact, more care is worse." Changing long-held consumer beliefs about the value of health care services will be essential to improving the cost and quality of care.

Negative reaction to past capitated payment arrangements was, in part, driven by overly aggressive gate-keeping approaches designed to create access barriers to specialty care. As a result, patients were suspicious that physicians and plans did not have their best interests at heart, leading employees to pressure employers to offer plans with fewer constraints. These sentiments were reinforced in the media and resonated because patients did not always experience care that felt patient-centered. One provider indicated that doctors had "lost track of the needs of the individual." In the absence of risk-adjusted payments, patients with complex health needs represented a cost burden to capitated providers. Often, patients with the greatest health care needs were among the least willing to accept limits in provider choice and direct access. In the absence of risk adjustment, these patients were not the most desirable for capitated providers.

The introduction of risk adjustment into global payment models changes this dynamic. Done correctly, risk adjustment combined with safeguards on the degree of risk assumption obviates this concern. Primary care providers managing patients under current global payment do not report the need to avoid sick patients and can focus on managing patients of all types. Providers all reported that their global payment arrangements were now risk-adjusted and all but one indicated they felt the risk adjustment was adequate.

While provider incentives around health status are now better aligned with patient resource needs, other patient incentives remain unaligned. Below are several ways that providers and plans suggested to improve care results and patient satisfaction under global payment.

Patients should opt in to global payment products. Plan products with global payment arrangements generally require a patient to designate their provider. These products often are characterized by more-limited networks and expectations that patients will work closely with their primary care physician and team. Patients might select these products for better care, better scores on quality metrics, and lower cost, but after many years of open access PPO plans, they may be even less comfortable than they were in the 80s and 90s with the idea of limited provider choice.

Employers have struggled to offer acceptable plan and benefit design choice to employees while holding down administrative costs and capitalizing on the convenience of offering only one or two uniform national plans. Forcing employees into plans with more restricted access to physicians became problematic for many employers, leading to growth in open access PPO products. Some experts noted that plans featuring more narrow networks of providers and requiring patient commitment to work with designated providers are better suited to the insurance exchanges contemplated under current health reform proposals or to an individual insurance market

where patients can opt in without a prior offering decision by their employer. Providers felt that in today's environment of job losses and eroding access to coverage, if patients are given a financial incentive to opt into a more limited network, many will be likely to do so. As one provider put it, "Choice is no longer king. Having health insurance is king."

Providers indicated they can achieve the best results when patients understand they will be working closely together with their providers on the management of their care. As one provider put it, "We tell them if they don't want their primary care doctor involved in all their care, this is probably not a good plan for them." Another provider organization has staff work directly with patients to help them understand their plan options and make sure they select the product that will work best for their needs and preferences. A former plan executive suggested that patients should be offered the choice of an open-network, high-deductible plan or a plan with more generous benefits that comes with a requirement to select a provider system. He estimated that 70 percent would opt for the narrower network with more comprehensive benefits.

Some plans are starting to offer products that allow choice of provider at the time of service while incorporating global payment arrangements with key network providers. In these products, patients are attributed to various providers based on their actual use patterns rather than requiring a predesignation. While potentially less able to proactively manage patient flow, these types of plans can fill a gap between more tightly managed networks and complete open access.

Patient benefits should be better aligned. While providers can counsel patients on what kinds of interventions are most appropriate, the lack of patient exposure to costs makes it more challenging for providers to engage their patients to optimize resource use. Most providers and payers felt that it would not be possible to curb patient demand for out-of-network care and, to a lesser extent, unnecessary care in the absence of patient economic participation.

A number of providers felt strongly that if primary care physicians have established trusting relationships with their patients, those physicians are well positioned to counsel patients into the right care at the right time. Some providers felt that physician extenders were less able to manage patient requests for unnecessary care, either because they have less developed relationships or are not perceived to have as much professional authority.

Not all providers saw patient demand as a significant issue. One provider articulated that "Patients don't drive demand, doctors do." While most providers felt that broad public awareness of the issues inherent to fee-for-service could substantially improve the effectiveness of global payment, some felt the most important audience for this message was actually physicians.

While providers often philosophically supported deductible and coinsurance benefit structures, these designs are less easily implemented when providers are part of a global payment arrangement. At the same time, plan benefits should financially engage patients in value decisions about care. Without an underlying fee-for-service payment structure, it is not clear how these services should be applied against a deductible or how much should be collected for coinsurance. Both providers and plans indicated that benefit structures should be refined to reduce barriers to essential care. Some interviewees proposed that most of the value of patient cost-sharing could be accomplished by establishing copays for certain types of services. Examples include waiver of patient cost-sharing for care management services such as between-visit contacts and follow-up from the care team, diabetic prescriptions and supplies, and patient education, along with introduction of higher copays for services such as high-tech imaging and services, procedures for which there is equivocal evidence of effectiveness, or care that is preference-based. Another idea is to fully cover evidence-based, provider-recommended protocols while charging higher copays for any other care alternative. When patients have a corresponding economic stake in care decisions, aligned providers (armed with cost and effectiveness information) would be better positioned to help patients optimize the value of their health care dollars.

Providers also felt it would be helpful for patients to have differential coinsurance levels for going out-of-network. This type of benefit structure has already been in use in some geographic markets, where it serves as a safety valve for patients who develop new health issues after they have enrolled with a particular provider system. Plans and providers cited substantial growth in plans that create benefit or premium incentives for patients to use lower-cost and higher-quality providers. Several interviewees felt this would inevitably become the norm in the marketplace.

Plans and providers felt that patient incentives to follow care recommendations or achieve defined health outcomes would have the potential to greatly improve patient compliance with care recommendations. When coupled with global payment, this type of benefit structure would better align patients and providers and would reduce patient suspicions of provider and plan incentives. Similarly, it was recommended that even patients without chronic illnesses should have incentives to make better lifestyle choices, such as smoking cessation and maintenance of ideal body weight. One provider suggested aligning patient incentives for performance by cutting them in on the gain share that was achieved over the global payment target.

The role of employers has been limited and has not driven change. While employers remain at the center of nonpublic plan purchasing of health coverage, several people interviewed expressed concern that employer purchasing decisions have not helped improve cost and quality.

Those interviewed did not believe that employers were likely to drive change in this direction. In many communities the largest employers actually are the plans and providers. And while more employers are expressing concerns about health care cost and quality than in the past, those interviewed felt that there has been no consistent voice and limited leadership.

SUMMARY AND CONCLUSIONS

The individuals interviewed for this paper had a wide range of national and international experience and expertise. Without exception, they felt strongly that to deliver better health care value it is essential that most provider reimbursement occur under the broad rubric of global payment. Provider payment based on total cost of care should be coupled with payment structures that recognize the outcomes of care, ideally based on functional outcomes rather than processes of care or intermediate outcomes.

Not everyone is, or should be, guaranteed success in this new world of incentives. Smaller physician practices can succeed in a market organized around global payment. Vehicles exist and more will emerge for providers of all shapes and sizes to participate. But, even in a staged transition to global payment, some providers may not prosper in this environment. Not all primary care providers will respond effectively to this change in incentives, and better management of patient care is expected to generate a surplus of hospitals and specialists that will need to be redeployed.

CMS must lead. Opinions were very clear and consistent that, in the absence of appropriate actions by CMS, the private market could not drive enough change. Conversely, several interview subjects stated that if CMS redefined its payment model in a meaningful way, the health care delivery world would respond quickly to the new incentives. Even though these experts agreed that a multiyear transition period would be important to delivery system stability, knowing in advance how they will be paid at the end of the transition period would have a dramatic, transformative effect on the delivery system, creating opportunities for innovation and improvement.

Providers and plans will need time to transition into their new roles. Moving to a global payment-dominated health care delivery market requires profound changes in thinking and behavior for provider and plan organizations and individuals. Making the transition while limiting disruption will require lead time as well as access to supporting resources.

Primary care capacity is the cornerstone of change. Improvements in primary care working conditions and rewards are necessary to ensure adequate supply. Methods for optimizing primary physician capacity include those that could free up physician time (e.g., efficiencies from fully implemented electronic medical records, and better use of physician extenders), but these

changes will only occur if the economics can support them. There is an expectation that widespread use of global payment models will result in excess specialist capacity in some specialty types. Some of those specialists may redeploy into primary care.

A number of approaches to global payment should be designed and supported. The details of how global payments are designed and implemented are less important than the alignment of incentives and ability to innovate to improve cost and quality. Design and administrative details should remain flexible to allow a variety of provider types and sizes to operate under global payment models. The use of risk-limiting approaches is important to enabling global payment to be used across the widest possible segment of the health care delivery system, but the infinite permutations of these variables could be more standardized. For example, global payment arrangements could come standard with risk adjustment applied, but could have a set of reinsurance options, based on the needs of the provider group. Or a more common approach to determining which services are included in the global payment could be established, coupled with a choice of several preestablished levels of up- and downside risk-limiting corridors.

Bring back the FTC. Global payment models are expected to drive provider consolidation, with attendant pros and cons. It is important to ensure that the positive aspects of consolidation and integration are encouraged, while excess market power and solidification of excessively high costs are avoided.

Though not easy, the public consciousness of what constitutes value in health care needs to be raised. It is not yet clear how to engage the public in an unbiased, nonpoliticized discussion of the value of health care interventions and the tradeoffs involved in health care spending. Fears of withholding necessary care in the presence of incentives to manage cost are widespread. As providers take on more risk, animosity toward insurance companies may transfer to providers. It is essential to align patient incentives to engage in value decisions about care and commit to actions to support their health.

Without the improved incentives for cost and quality performance that will come with global payment, experts expressed deep concerns that other health reforms that bring more individuals into our existing system will exacerbate existing cost problems.

APPENDIX A

PROVIDER INTERVIEW QUESTIONS

COMMONWEALTH FUND INTERVIEW QUESTIONS

CAN IT WORK?

1. Do you think moving to broadly implemented global payment strategies can address U.S. concerns about growth in health care costs? How big an impact can be achieved?

2. Do you think global payment is the best way to align economic incentives? Are there ways other than global payments that would achieve sufficient alignment? What would you suggest for smaller providers?

3. What are the key issues to make sure the next generation of global payments gets it right? What would make it fail? What are the biggest pitfalls to avoid?

4. Does CMS need to change its underlying structures (RBRVS, DRG, APC) and weights for global payments to work? Why or why not?

5. Does the balance of power among primary care physicians, specialists, and hospitals need to change to get costs under control? Can that be done using global payments? Are there other ways to accomplish this?

6. Do you think global payment can achieve results that can't be achieved through episode payments? Do you think episode payments can achieve results that can't be achieved through global payments? Do episode payments and global payments have any inherent incentive conflicts that would concern you? Do you think they can, or should, be done jointly? Which approach should be primary?

7. Do you think some modified form of global payment can be applied to smaller practices? How would you suggest this be done?

8. Do you think a market dominated by global payment will result in a reduction of existing health delivery capacity? Do you think making global payment the dominant form of reimbursement will drive too much provider consolidation?

9. Are there other ways to reduce the trend in health care costs? What are they?

HOW WOULD YOU RESPOND?

10. What share of patients need to be in a global payment program to allow you to optimize your performance? Can you get to a critical mass if different plans pay in slightly different ways as long as they all have an overriding incentive to manage total cost and quality? Does it matter to you which way the payment systems work as long as there is an incentive for cost and quality management? What features are essential?

11. If you knew that the majority of your reimbursement was going to be under some form of global payment arrangement by 2015, what would you do now to prepare for that?

12. Historically much of the savings from population based payment models has revolved around reduction in inpatient use. What problems and opportunities for these savings are introduced with vertical integration of providers? Will there be barriers for physicians owned by large hospital systems to reduce inpatient use?

13. How would you decide if you were performing successfully under a global payment arrangement? In a capitated environment, do underlying FFS systems still matter? How are they used?

14. Can you do the kind of cost accounting that you need under a global payment model to assess how to best deploy your resources and understand how you are doing financially?

15. What are the primary issues related to reinsurance and other risks? How would you suggest these be addressed?

16. Have you successfully aligned incentives with providers not under your immediate control? How? Are there other ways to "bring them into the tent" that should be explored? How big a concern is this?

17. Have you successfully aligned incentives with individual providers within your organization? How have you accomplished this? If not fully aligned, has this been a material problem or barrier for success?

18. Have you unraveled any infrastructure that was important to managing under a global payment? Would you need to recreate infrastructure? How long would it take? What would it take to get you to make the necessary investments to do that?

PLAN DYNAMICS

19. How do you think the level of global payment should be set? What, if anything, should be done about the differences in global payment levels among systems of care?

20. Would you negotiate your global payment level differently if you knew that patients would have to pay more for higher cost providers?

21. In the past, what happened if you spent more than your capitation? What happened if you spent less? Did the tax implications of creating a reserve drive your investment and distribution decisions?

22. What is your experience with plan capabilities to administer global payments? Are they more or less capable of administration of these models today? What's changed?

23. Can plans give you the data you need to take action? What data do you need? Will plans give you the data you need? How can that be accomplished?

24. Have you tried to negotiate a capitation or global payment arrangement with one or more plans in the last year? What has been the result?

25. Is there a different value added role for the plan in a market dominated by global payment arrangements?

PATIENT DYNAMICS

26. Were your patients concerned/suspicious about your care decisions when you were at risk? Would/did you treat fee-for-service patients differently in any way? How?

27. Was consumer distrust and backlash a material issue for you under global payment models? Are you concerned about consumer backlash regarding fear of withheld care if we move to global payments? How would you suggest this be addressed?

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28. In the absence of adequate risk adjustment, would/did you attempt to avoid sick or potentially sick patients? How?

29. How would you suggest consumer incentives be aligned with provider incentives under global payment?

30. Do you think patients are more or less willing today to identify and stick with their provider or provider organization?

31. How important do you think consumer messaging on global payment will be to its success? Would you anticipate opponents of this approach attempting to raise public concerns about its impact on them?

Appendix B

PAYER INTERVIEW QUESTIONS

COMMONWEALTH FUND PAYER INTERVIEW QUESTIONS

CAN IT WORK?

1. Do you think moving to broadly implemented global payment strategies can address U.S. concerns about growth in health care costs? How big an impact can be achieved?

2. Do you think global payment is the best way to align economic incentives? Are there ways other than global payments that would achieve sufficient alignment? What would you suggest for smaller providers?

3. What are the key issues to make sure the next generation of global payments gets it right? What would make it fail? What are the biggest pitfalls to avoid?

4. Does CMS need to change its underlying structures (RBRVS, DRG, APC) and weights for global payments to work? Why or why not?

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5. Do you think global payment can achieve results that can't be achieved through episode payments? Do you think episode payments can achieve results that can't be achieved through global payments? Do episode payments and global payments have any inherent incentive conflicts that would concern you? Do you think they can, or should, be done jointly? Which approach should be primary?

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6. Do you think a market dominated by global payment will result in a reduction of existing health delivery capacity? Do you think making global payment the dominant form of reimbursement will drive too much provider consolidation?

7. Are there other ways to reduce the trend in health care costs? What are they?

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8. Has the way you contract global payments changed in significant ways? How?

PROVIDER RESPONSE

9. What share of patients do providers need in a global payment program to allow them to optimize performance? Can they get to a critical mass if different plans pay in slightly different ways as long as they all have an overriding incentive to manage total cost and quality?

10. If providers knew that the majority of their reimbursement was going to be under some form of global payment arrangement by 2015, what do you think they would do now to prepare for that?

11. Historically much of the savings from population based payment models has revolved around reduction in inpatient use. What problems and opportunities for these savings are introduced with vertical integration of providers? Will there be barriers for physicians owned by large hospital systems to reduce inpatient use?

12. How do the contracted providers decide if they are performing successfully under a global payment arrangement? In a capitated environment, do underlying FFS systems still matter? How are they used?

13. What are the primary issues related to reinsurance and other risks? How would you suggest these be addressed?

14. Have you successfully aligned incentives with providers not directly under a global payment contract? How? Are there other ways to "bring them into the tent" that should be explored? How big a concern is this?

15. Have the provider systems successfully aligned incentives with individual providers? How? If not fully aligned, has this been a material problem or barrier for success?

16. Have you unraveled any infrastructure that was important to managing global payments? Would you need to recreate infrastructure? How long would it take? What would it take to get you to make the necessary investments to do that?

PLAN DYNAMICS

17. How do you think the level of global payment should be set? What, if anything, should be done about the differences in global payment levels among systems of care?

18. Would you and the providers negotiate global payment levels differently if patients had to pay more for higher cost providers?

19. What happens if providers spent more than their capitation? What happens if they spend less?

20. Does your plan have sufficient flexibility to administer global payments? What do you do for self funded employers?

21. Is there a different value added role for the plan in a market dominated by global payment arrangements?

PATIENT DYNAMICS

22. Are members concerned/suspicious about care decisions when providers are at risk? Are fee for service patients treated differently in any way? How?

23. In the absence of adequate risk adjustment, do you think providers attempt to avoid sick or potentially sick patients? How?

24. How would you suggest consumer incentives be aligned with provider incentives under global payment?

25. Do you think members are more or less willing today to identify and stick with their provider or provider organization?

26. How important do you think consumer messaging on global payment will be to its success? Would you anticipate opponents of this approach attempting to raise public concerns about its impact on them?

Appendix C

PROVIDER SURVEY

THE VOICE OF EXPERIENCE: LESSONS FOR GLOBAL PAYMENT MODELS
PROVIDER BACKGROUND QUESTIONNAIRE FOR INTERVIEW SUBJECTS

Your Name _____
Organization name _____
Date _____

The following background information will help to focus our discussion time. It is intended to be completed quickly. Please respond generally, based on your most recent experience with a capitation program. Exact information is not required.

GENERAL BACKGROUND

1. Number of PCPs _____
2. Number of unique locations _____
3. Number of specialists _____
4. For how many years has your organization been paid on capitation? _____
5. Most recent year for which you were capitated? _____
6. What was the largest percentage of your patient population that was capitated?_____
7. Please describe your delivery system, as it existed when you were capitated (check all that apply)

_____Contracted Primary Care IPA
_____Contracted Primary and Specialty IPA
_____PHO
_____Primary care group practice
_____Multispecialty clinic (outpatient care only)
_____Multispecialty clinic with inpatient facility
_____Other, please describe _____

FINANCIAL BACKGROUND

8. With how many plans do you have capitation contracts at any one time? _____
9. For what services are you at risk? (check all that apply)

_____Global (all covered services)
_____Outpatient services only

_____Outpatient services without pharmacy

_____Physician services only

_____Primary care services only

_____Other, please describe _____

_____

10. Are your capitation rates risk adjusted? ____Yes ____No
11. If yes, is the risk adjustment adequate to address population illness burden ____Yes ____No
12. Reinsurance
    - _____Providers purchase reinsurance
    - _____Plan caps exposure
13. How are costs in excess of capitation funded?
    - _____Provider held reserve
    - _____Plan held reserve
    - _____Plan guarantees minimum fee for service equivalent
14. Percentage of total claim dollars or PMPM amount allocated to management and infrastructure?
    - _____ % of total cost of care dollars (specify %) or,
    - _____PMPM $ amount (specify $ amount)

15. Cash flow method (check all that apply)
    - _____Plan deposits entire capitation prospectively into provider account
    - _____Plan deposits part of capitation prospectively into provider account
    - _____Plan cash flows dollars based on claims submitted
    - _____You distribute funds for services outside of system
        - _____hospital and other facility claims
        - _____specialty claims
        - _____pharmacy claims
        - _____allied and ancillary claims
    - _____Plan distributes funds for services outside of system
        - _____hospital and other facility claims
        - _____specialty claims
        - _____pharmacy claims
        - _____allied and ancillary claims

PROVIDER REIMBURSEMENT

16. How are your individual physicians paid? (Check all that apply)

_____Productivity
_____Productivity plus bonus on performance against capitation
_____Productivity plus bonus/penalty on performance against capitation
_____Shared practice profit without individual productivity
_____Salary
_____Salary plus bonus on profitability
_____Other (please specify)

17. How are physicians outside the capitated practice paid? (Check all that apply)

_____Negotiated fee for service
_____Case rate/contact capitation
_____Sub-capitation
_____Other (please specify)

18. How are facilities outside of the capitated group paid? (Check all that apply)

_____Case rate/contact capitation
_____Negotiated fee for service
_____Sub-capitation
_____Per diem
_____DRG
_____Other (please specify)

DATA AVAILABILITY

19. What data is available to you? (Check all that apply)

	Financial data	Utilization data	Quality data
Internally generated data	_____	_____	_____
Periodic plan summaries	_____	_____	_____
Electronic detailed data	_____	_____	_____
Other, please specify	_____	_____	_____

COST AND QUALITY MANAGEMENT TOOLS

20. Which of the following do you think are important for your ability to successfully manage capitation?

Reimbursement and patient steerage

____Fee negotiation with downstream providers
____Risk sharing with downstream providers
____Steerage to high performance doctors and hospitals
____Exclusion of particular providers from network
____Management of patient access to specialty providers (e.g. gatekeeper approach)
____Owned imaging and ancillary services

Outpatient care coordination activities

____Evidence- based, standardized practice protocols
____Physician extenders/ care team/care managers
____Pre-visit planning
____Patient initiated phone consults with physicians or care team
____Patient initiated web visits with physicians or care team
____Proactive phone outreach to chronically ill
____Proactive web outreach to chronically ill
____Referral to community based resources
____Formal process for shared decision making with patient
____Imaging and/or lab use management program

Emergency room and admission management

____Non-hospital based urgent care access
____Extended office hours
____Network physicians meet patients at ER
____Onsite hospitalists
____Onsite admission and discharge managers

Medication management

____Patient consults with pharmacists (pharmaceutical care)
____Generic replacement program
____Internally determined formulary
____Specialty pharmacy management programs

Other

____Common or interoperable electronic medical record
____Healthier population
____Ability to negotiate capitation rate successfully

____Other, please specify_____

____Other, please specify_____

ISSUES IN CAPITATION MANAGEMENT

21. Are any of the following material issues for you?

____Availability and/or cost of reinsurance
____Patient turnover
____Need to avoid sicker patients
____Inadequate capitation creates need to skimp on care
____Process of negotiating capitation level
____Cash flow/funding/reconciliation/downstream payments/claim systems capabilities
____Referral management systems
____Insufficient critical mass of capitated patients
____Inadequate data available to manage capitation
____Patient concerns about capitation payment model
____Lack of aligned patient economic incentives
____Patient demand for unnecessary care
____Patient demand for out of network care
____Lack of competition among hospitals and/or specialists
____Misaligned incentives for individual providers
____Misaligned specialist incentives
____Misaligned facility incentives
____Physician opposition to capitation
____Government regulation restrictions
____Malpractice coverage cost and availability
____Cost of defensive medicine practices
____Conflicts with plan based disease management initiatives
____Poor plan relationships
____Other,please specify _____
____Other, please specify _____

ENVIRONMENTAL CHANGES

22. Which of the following do you think could substantially improve the effectiveness of global payments?

____ Increased patient cost sharing at point of service
____ Increased patient premium cost sharing for choosing higher cost providers (e.g. value networks)
____ Public transparency on cost and quality
____ Use of patient owned personal health records
____ Broad public awareness of issues with fee for service payments
____ Standardized cost metrics
____ Standardized quality metrics
____ Standardized reimbursement methods
____ More provider consolidation
____ Limits on provider consolidation
____ Increased plan consolidation
____ Limits on plan consolidation
____ Use of risk adjustment
____ Streamlined claim systems with common standards
____ Comprehensive electronic claim data availability for providers
____ Greater plan involvement in care management activities
____ Reduced plan involvement in care management activities
____ Access to capital for patient management infrastructure
____ Full implementation of electronic medical records
____ Changes in underlying CMS RBRVS, APC and DRG payment structures
____ Normalization of reimbursement rates between public and private payers
____ Agreement on national goals for cost and quality
____ Technical support for providers transitioning from fee for service to global payments
____ Reduction in the number of uninsured
____ Other, please describe _____
____ Other, please describe _____
____ Other, please describe _____

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Appendix D

PAYER SURVEY

THE VOICE OF EXPERIENCE: LESSONS FOR GLOBAL PAYMENT MODELS
PAYER BACKGROUND QUESTIONNAIRE FOR INTERVIEW SUBJECTS

Your Name _____
Organization name _____
Date _____

The following background information will help to focus our discussion time. It is intended to be completed quickly. Please respond generally, based on your most recent experience with capitation contracts. Exact information is not required.

GENERAL BACKGROUND

23. Percent of plan members (book of business) capitated currently _____
24. What was the largest percentage of your member population that was capitated?_____
25. Number of markets capitated _____
26. For how many years has your organization been paying capitation? _____
27. Most recent year for which you were capitating providers? _____
28. Please describe the types of delivery systems with whom you have capitated contracts (check all that apply)

    _____Contracted Primary Care IPAs
    _____Contracted Primary and Specialty IPAs
    _____PHOs
    _____Primary care group practices
    _____Multispecialty clinics (outpatient care only)
    _____Multispecialty clinic with inpatient facilitys
    _____Other, please describe _____

FINANCIAL BACKGROUND

29. With how many provider organizations do you have capitation contracts? _____
30. For what services are they at risk? (check all that apply)

    _____Global (all covered services)
    _____Outpatient services only
    _____Outpatient services without pharmacy

_____Physician services only

_____Primary care services only

_____Other, please describe _____

_____

31. Are your capitation rates risk adjusted? ____Yes ____No
32. If yes, is the risk adjustment based on diagnosis mix? ____Yes ____No
33. Reinsurance
    - _____Providers purchase reinsurance
    - _____Plan caps exposure
34. How are costs in excess of capitation funded?
    - _____Provider held reserve
    - _____Plan held reserve
    - _____Plan guarantees minimum fee for service equivalent
35. Percentage of total claim dollars or PMPM amount allocated to providers for capitation management and infrastructure?
    - _____ % of total cost of care dollars (specify %) or,
    - _____PMPM $ amount (specify $ amount)
36. Cash flow method (check all that apply)
    - _____Plan deposits entire capitation prospectively into provider account
    - _____Plan deposits part of capitation prospectively into provider account
    - _____Plan cash flows dollars based on claims submitted
    - _____Providers distribute funds for services outside of system
        - _____hospital and other facility claims
        - _____specialty claims
        - _____pharmacy claims
        - _____allied and ancillary claims
    - _____Plan distributes funds for services outside of system
        - _____hospital and other facility claims
        - _____specialty claims
        - _____pharmacy claims
        - _____allied and ancillary claims

PROVIDER REIMBURSEMENT FOR NON-CAPITATED PROVIDERS THAT PROVIDE CARE TO PATIENTS IN CAPPED PROGRAMS

37. How are physicians outside the capitated practice paid? (Check all that apply)

_____Negotiated fee for service

_____Case rate/contact capitation

_____Sub-capitation

_____Other (please specify)

38. How are facilities outside of the capitated group paid? (Check all that apply)

_____Case rate/contact capitation

_____Negotiated fee for service

_____Sub-capitation

_____Per diem

_____DRG

_____Other (please specify)

39. Who contracts for these services?

	Plan	Provider taking cap
Specialists	____	____
Hospitals	____	____
Other, please specify	____	____

_____

DATA AVAILABILITY

40. What data do you provide to capitated providers? (Check all that apply)

	Financial data	Utilization data	Quality data
Plan generated summary data	_____	_____	_____
Plan generated claim detail	_____	_____	_____
Plan generated electronic detail	_____	_____	_____
Other, please specify	_____	_____	_____

COST AND QUALITY MANAGEMENT TOOLS

41. Which of the following do you think are important for successful capitation management?

Reimbursement and patient steerage

____Provider led fee negotiation with downstream providers
____Risk sharing with downstream providers
____Steerage to high performance doctors and hospitals
____Exclusion of particular providers from network
____Management of patient access to specialty providers (e.g. gatekeeper approach)
____Owned imaging and ancillary services

Outpatient care coordination activities

____Evidence- based, standardized practice protocols
____Physician extenders/ care team/care managers
____ Pre-visit planning
____ Patient initiated phone consults with physicians or care team
____ Patient initiated web visits with physicians or care team
____ Proactive phone outreach to chronically ill
____ Proactive web outreach to chronically ill
____ Referral to community based resources
____ Formal process for shared decision making with patient
____ Imaging and/or lab use management program

Emergency room and admission management

____Non-hospital based urgent care access
____Extended office hours
____Network physicians meet patients at ER
____Onsite hospitalists
____Onsite admission and discharge managers

Medication management

____Patient consults with pharmacists (pharmaceutical care)
____Generic replacement program
____Internally determined formulary
____Specialty pharmacy management programs

Other

____Common or interoperable electronic medical record
____Healthier population
____Ability to negotiate capitation rate successfully

____Other, please specify_____

____Other, please specify_____

ISSUES IN CAPITATION MANAGEMENT

42. Are any of the following material issues for you as a payer?

____Availability and/or cost of reinsurance

____Patient turnover

____Concerns with attraction of sicker patients

____Process of negotiating capitation level

____Cash flow/funding/reconciliation/downstream payments/claim systems capabilities

____Plan overhead costs for capitated contracting and administration

____Referral management systems

____Insufficient critical mass of capitated patients

____Patient/employer concerns about capitation payment model

____Lack of aligned patient economic incentives

____Increased customer service issues

____Patient demand for unnecessary care

____Patient demand for out of network care

____Lack of competition among hospitals and/or specialists

____Misaligned incentives for individual providers

____Misaligned specialist incentives

____Misaligned facility incentives

____Physician opposition to capitation

____Government regulation restrictions

____Conflicts with provider based disease management initiatives

____Poor provider relationships

____Other, please specify _____

_____

____Other, please specify _____

_____

ENVIRONMENTAL CHANGES

43. Which of the following do you think could substantially improve the effectiveness of global payments?

____ Increased patient cost sharing at point of service

____ Increased patient premium cost sharing for choosing higher cost providers (e.g. value networks)

____ Public transparency on cost and quality

____ Use of patient owned personal health records

____ Broad public awareness of issues with fee for service payments

____ Standardized cost metrics

____ Standardized quality metrics

____ Standardized reimbursement methods

____ More provider consolidation

____ Limits on provider consolidation

____ Increased plan consolidation

____ Limits on plan consolidation

____ Use of risk adjustment

____ Streamlined provider billing systems with common standards

____ Comprehensive electronic claim data availability for plans and providers

____ Greater provider involvement in care management activities

____ Reduced provider involvement in care management activities

____ Access to capital for provider management infrastructure

____ Full implementation of electronic medical records

____ Changes in underlying CMS RBRVS, APC and DRG payment structures

____ Normalization of reimbursement rates between public and private payers

____ Agreement on national goals for cost and quality

____ Technical support for providers transitioning from fee for service to global payments

____ Reduction in the number of uninsured

____ Other, please describe _____

_____

____ Other, please describe _____

_____

____ Other, please describe _____

_____

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Appendix E

INTERVIEW SUBJECTS

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Charles Fazio, MD
Senior Vice President and Chief Medical Officer
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Randall P. Herman, FSA
Co-founder, Reden and Anders
Co-founder, Patient Choice Healthcare, Inc.

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Jeff Levin-Scherz, MD, MBA
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Robert Margolis, MD
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